

Missouri Medicaid Professional Billing Book



Missouri Department of Social Services
Division of Medical Services

Created by the Provider Education Unit

MISSOURI MEDICAID
PROFESSIONAL BILLING BOOK
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PREFACE

This Professional Training Booklet contains information to help you submit claims correctly. The information is only recommended for Missouri Medicaid providers and billers if your Medicaid provider number begins with 20, 24, 25, 30, 35, 36, 42, 50, 51, 52, 54, 55, 70, 71 and 91. The booklet is not all-inclusive of program benefits and limitations; providers should refer to specific program manuals for entire content.

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SECTION 1.

MEDICAID PROGRAM RESOURCES

Informational Resources available at www.dss.mo.gov/dms

CONTACTING MEDICAID

PROVIDER COMMUNICATIONS

The following phone numbers are available for Medicaid providers to call the Provider Communications Unit with provider inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and recipient eligibility questions and verification. The toll free line provides an interactive voice response system that can answer questions regarding matters including recipient eligibility, last two check amounts, claim status and procedure code status. Providers must use a touchtone phone to access the system.

| | |
|----------------------------------|--------------|
| Provider Communications | 800/392-0938 |
| Interactive Voice Response (IVR) | 800/392-0938 |
| Standard Line | 573/751-2896 |

The Provider Communications Unit also processes written inquiries. Written inquiries should be sent to:

Provider Communications Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

VERIZON INFORMATION TECHNOLOGIES HELP DESK **573/635-3559**

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Verizon Internet billing service.

PROVIDER ENROLLMENT

Providers can contact Provider Enrollment via email as follows for questions regarding enrollment applications: providerenrollment@mail.medicaid.state.mo.us

Changes regarding address, ownership, tax identification number, name (provider or practice), or Medicare numbers are to be submitted in writing to:

Provider Enrollment Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

THIRD PARTY LIABILITY

573/751-2005

Call the Third Party Liability Unit to report injuries sustained by Medicaid recipients, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a Medicaid recipient.

PROVIDER EDUCATION

573/751-6683

Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for Medicaid claims. Contact the Unit for training information and scheduling.

RECIPIENT SERVICES

800/392-2161 or 573/751-6527

The Recipient Services Unit assists recipients regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

MEDICAID EXCEPTIONS AND DRUG PRIOR AUTHORIZATION HOTLINE

800/392-8030

Providers can call this toll free number to initiate a request for an essential medical service or an item of equipment that would not normally be covered under the Medicaid program, or to request a drug prior authorization. The Medicaid exceptions fax line for non-emergency requests only is 573/751-2439.

HIPAA INFORMATION

Billing providers who want to exchange electronic information transactions with Missouri Medicaid can access the *HIPAA Companion Guide* online by going to the Division of Medical Services web page at www.dss.mo.gov/dms and clicking on the HIPAA Companion Guide link in the Quick Link box at the top of the page.

To access the *X12N Version 4010A1 Companion Guide*: 1) select Missouri Medicaid Electronic Billing Layout Manuals; 2) select System Manuals; 3) select Electronic Claims Layout Manuals; and, 4) select X12N Version 4010A1 Companion Guide.

For information on the Missouri Medicaid Trading Partner Agreement: 1) select Section 1 - Getting Started; and, 2) select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Verizon Help Desk, 573-635-3559.

INTERACTIVE VOICE RESPONSE (IVR)

800/392-0938

The Provider Communications Unit toll-free number, 800/392-0938 is answered by an Interactive Voice Response (IVR) unit which requires a touchtone phone. The nine digit Medicaid provider number **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

- Option 1 Recipient Eligibility
Recipient eligibility **must** be verified **each** time a recipient presents and should be verified **prior** to the service. Eligibility information can be obtained by a recipient's Medicaid number (DCN), social security number and date of birth, or if a newborn, using the mother's Medicaid number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.
- Option 2 Last Two Check Amounts
Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.
- Option 3 Claim Status
After entering the recipient's Medicaid number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).
- Option 4 Procedure Code Status
This option gives the caller the current status of a procedure code and current attachment requirements. Additional instructions on how to use this option are contained in Section 3 of the *Medicaid Provider Manual*.
- Option 5 Medicaid Information Messages
The caller will be given the option to select from several recorded messages providing the latest information about the Medicaid program.

INTERNET SERVICES FOR MEDICAID PROVIDERS

The Division of Medical Services (DMS), in cooperation with Verizon Information Technologies, has an Internet service for Missouri Medicaid providers. Missouri Medicaid providers have the ability to:

- ★ Submit claims and receive claim confirmation files;
- ★ Verify recipient eligibility;
- ★ Obtain remittance advices (RAs);
- ★ Submit Adjustments;
- ★ Submit attachments; and
- ★ View and download public files.

The web site address for this service is www.emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the web site services. To participate, the provider must contact the Verizon Information Technologies help desk at (573) 635-3559 to obtain an Application for Missouri Medicaid Internet Access Account. A copy of the application is included later in this section. It is available also at the DMS web site, www.dss.mo.gov/dms. The application must be completed and returned to:

Verizon Information Technologies
ATTN: EMC Coordinators
P.O. Box 177
Jefferson City, MO 65102-0177

Once the application has been processed and approved, the applicant will receive a certified letter with the information required to begin using the web site. The letter will include a user ID and an initial password. The user can later change the password to one of the user's own choice.

An authorization is required for each individual person within a provider's office who will be accessing the Internet site.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements, however, the user (provider) must have the proper web browser. The provider must have one of the following web browsers: Internet Explorer 5.0 or higher or Netscape 4.7 or higher. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING RECIPIENT ELIGIBILITY THROUGH THE INTERNET

Providers can access Missouri Medicaid recipient eligibility files via the web site. Functions include eligibility verification by recipient ID, casehead ID and child's date of

birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occur in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

MEDICAID CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

- ▶ 837 - Health Care Claim
 - Professional
 - Dental
 - Institutional (hospital inpatient and outpatient, nursing home, and home health care)
- ▶ Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

NOTE: Currently, some claims may not be submitted electronically if an attachment is required unless the attachment is one of the following: Sterilization Consent form, DME Certificate of Medical Necessity, Acknowledgment of Receipt of Hysterectomy Information form, Second Surgical Opinion form or the SURS 118 Referral form.

OBTAIN THE REMITTANCE ADVICE THROUGH THE INTERNET

Providers have the capability to receive and download a Remittance Advice (RA) from the Internet. The RA format complies with the HIPAA 835, Health Care Claim Payment Advice, regulation. Access to this information is restricted to users with proper authorization. The RA must be downloaded in order to be viewed or printed by the provider. Access to this confidential information is restricted to authorized persons only. Call the Verizon Information Technologies Help Desk at 573/635-3559 for required program formats and the Remittance Advice agreement.

ADJUSTMENTS THROUGH THE INTERNET

Providers have options on the Internet Medical, Dental, Inpatient, Outpatient and Nursing Home claims for a "Frequency Code" that will allow either a 7 – Replacement

(Adjustment) or an 8 – Void (credit). This will control an individual adjustment or void, but not group adjustments or voids. Claim adjustments and credits can be submitted by utilizing the CLM, field CLMO5-3, segment of the 837 Health Care Claim.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

Several public files are available for viewing or downloading from the web site including the claims processing schedule for the current fiscal year that begins July 1 and ends June 30. Providers also have access to a listing of the Adjustment Reason Codes and Remittance Advice Remark Codes.

SUBMIT ATTACHMENTS AND FORMS THROUGH THE INTERNET

Providers can submit attachments and forms via the Internet as an option to mailing paper versions to Medicaid. The following documents can be submitted through the Internet service.

| | |
|---|---|
| Prior Authorization | SURS 118 Referral (administrative lock-in) |
| Sterilization Consent | Certificate of Medical Necessity (DME only) |
| Second Surgical Opinion | |
| Acknowledgment of Receipt of Hysterectomy Information | |

Verizon



Application for Missouri Medicaid Internet Access Account

Please print or type information and thoroughly complete steps 1 - 4. *Questions? Call 573-635-3559.*
Complete this form for each person requiring an id and password. Id and password may not be shared between users of the Emomed.com application.

1. User Information – Please type or print legibly

Name of Individual User (first, middle, last)

Social Security Number

Birth Date (mm-dd-yy)

Business Street Address (no P.O. Box)

Business City & State

Business Zip code

(_____)_____
Business Telephone Number

Internet email address (e.g. userid@company.com)

Helpdesk Security Question

(For security reasons, you will be asked for a 'helpdesk security word' when calling for account activities such as password resets. In the event you forget your 'helpdesk security word', the helpdesk person will use this question to jog your memory. Examples include 'What is my mother's maiden name?', 'What is my favorite flavor of ice cream?', etc.)

Helpdesk Security Word

(This word is the answer to the question on the left.)

2. Authorized Medicaid Provider Names & Numbers (please provide all Medicaid Provider Names & Numbers for which you are authorized to manage electronic claim information.) Attach additional sheet if needed.

Provider Name

Provider number

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Provider Name

Provider number

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3. Agreement and Signature

The Undersigned acknowledges, understands and agrees that records and information which are related to the Missouri Medicaid program are confidential and shall be released or revealed only to authorized persons as provided for by law. The Undersigned understands and agrees that state and federal law mandate confidentiality of patient and provider health care information and provide substantial civil and criminal penalties for unauthorized access, use, or disclosure of confidential patient and provider information. The Undersigned on behalf of the business entity and himself or herself acknowledges to keep and maintain confidential all patient and provider information and to only disclose same in the performance of the Undersigned's or the business entity's official duties. In the event the Undersigned or the business entity for whom the Undersigned is employed or acting as agent therefore shall violate state and federal law related to the confidentiality of patient or provider information, the Undersigned and the business entity employing the Undersigned or for whom the Undersigned is an agent thereof shall indemnify, defend and hold Verizon Data Services Incorporated, its parent, affiliates, subsidiaries and contractors harmless from and against any and all claims, demands and actions, (without limiting the generality of the foregoing) which arise out of or relate to any violation of federal and state law, and shall pay all costs including, but not limited to, attorney's fees, judgments, investigative costs and court costs. The Undersigned represents and warrants that he or she has the authority to sign and bind the business entity.

Legal Name of Business Entity

| | | |
|--|---|---|
| MUST BE SIGNED IN PRESENCE OF NOTARY | SIGNATURE OF APPLICANT ▶ | DATE |
| NOTARY INFORMATION | | |
| NOTARY PUBLIC EMBOSSEER SEAL | STATE OF | COUNTY |
| | SUBSCRIBED AND SWORN BEFORE ME, THIS | |
| | DAY OF | 20__ |
| | NOTARY PUBLIC SIGNATURE ▶ | MY COMMISSION EXPIRES |
| NOTARY PUBLIC NAME (TYPED OR PRINTED) | | USE RUBBER STAMP IN CLEAR AREA BELOW |
| | | |

4. Mail Form to (faxes are not allowed):

Verizon
 Attn: EMC Coordinators
 P.O. Box 177
 Jefferson City, MO 65102-0177

NOTE: after your request is approved and processed, you will receive a certified letter in the mail with all information required to begin using your account. Thank you.

Internal Use Only**Approved By****Account Number****Date processed**

MISSOURI MEDICAID PROVIDER MANUALS ON-LINE

www.dss.mo.gov/dms

How To Download/Print a Provider Manual

The following information assumes you are using a Microsoft Windows based operating system as your operating system. In order to be able to download and use all or a portion of an on-line Medicaid provider manual, you must have Adobe Acrobat Reader. If you already have this on your computer, you may disregard the first section and go directly to the sections detailing how to download and print the manuals.

NOTE: The provider manual information you download is current as of the time it is downloaded. Since periodic updates are made to the manuals, you must do a new download periodically so that your file will have the new or updated information.

A. Accessing and downloading Adobe Acrobat Reader program .

1. Open the DMS home page at www.dss.mo.gov/dms.
2. Scroll down, click on and open the line/link titled "Missouri Medicaid Provider Manuals".
3. In the newly opened page, scroll down and click on the yellow and red box at the bottom of the page titled "Get Acrobat Reader".
4. Once you have opened the Adobe Acrobat page, follow the instructions to download the free Adobe Acrobat Reader program to your computer system. Generally, the program will be installed in the C:/programs folder although you can put it in any folder you want. Download time is approximately 20-30 minutes depending on the speed of your modem and Internet service provider.

B. Downloading and saving all or portions of a provider manual.

1. Go to the DMS home page at www.dss.mo.gov/dms.
2. Scroll down, click on and open the line/link titled "Missouri Medicaid Provider Manuals".
3. A new page will open. Click on the link titled "Missouri Medicaid Provider Manuals".
4. On the left side of the newly opened page, click on the "+" in front of the folder titled "Print A Manual" and click again on the subfolder. This opens a new frame in the upper right area of the screen titled "Print a Manual". In this frame scroll down to the provider manual you want to access and click on the manual to open to its contents page. Disregard the frame in the lower area of the page titled "Search Results".
5. When the page opens, it will display a number of links from which you can choose the one you want. The links allow you to access either the complete manual or sections of the selected manual.

For Internet Explorer Browser Users

For example, if you wish to download the entire physician's manual, place your pointer on the line/link titled "Complete Manual" and right click. A pop-up

menu will appear. Click on the "Save Target As" button. Another pop window (Save As) will appear. Select where you want to save the file and its name. It can be saved either to a floppy disk or to a folder on the hard drive. If you rename the file, be sure to put the .pdf extension at the end of the new name. Click on the save button. The material then will be saved to the location/name you specified. Actual download time will vary depending on the file size of the information you want to download and the speed of your system's modem and your Internet service provider's system. Downloading a complete manual can take 5-10 minutes.

For Netscape Browser Users

For example, if you wish to download the entire physician's manual, place your pointer on the line/link titled "Complete Manual" and right click. A pop-up screen will appear. Click on "Save Link As". In the next pop-up window, select the drive/ folder where you want to save the data. You may rename file if you wish a name other than the name presented by the system. Add or change the file extension to .pdf (at the end of the file name), e.g. change phyman to phyman.pdf. Click save and the data will be saved to the location/name you specified. Actual download time will vary depending on the file size of the information you want to download and the speed of your system's modem and your Internet service provider's system. Downloading a complete manual can take 5-10 minutes.

6. Close the screens all the way back to the browser. Close the browser screen and return to your desktop.

C. Using Adobe Acrobat Reader to access the saved manual file.

1. Open Acrobat Reader either using the desktop icon or the program file.
2. Once the work screen is open, click on "File" in the taskbar.
3. On the task screen, select and click on "Open".
4. Select and highlight the drive location and name of your file. Acrobat Reader then will open your file.
5. You now have the option of viewing or printing all or portions of the file.

D. Printing all or portions of an opened Acrobat Reader Document

1. Click on "File" on the taskbar.
2. On the task screen, select and click on "Print" or "Print Target".
3. You have three options for printing from the file. All - prints the entire file
Current Page - prints only the page you have selected/highlighted. Pages - gives you the option to print a specified range of consecutive pages.
4. When the print command has been sent to the printer, select "File" on the taskbar and "Exit" in the task screen to exit the program and return to your desktop.

CLAIM AND ATTACHMENT MAILING ADDRESSES

Medicaid paper claims and attachments related to claims must be sent to the following address as indicated.

Verizon Information Technologies, Inc.
P.O. Box (see below for correct PO box number)
Jefferson City, MO 65102

P.O. Box 5100..... Inpatient Hospital Claims
P.O. Box 5200..... Outpatient Hospital Claims and RHC Claims
P.O. Box 5300..... Dental Claims
P.O. Box 5400..... Pharmacy Form Paper Claims
P.O. Box 5500..... Nursing Home Paper Claims
P.O. Box 5600..... DME, HCFA-1500, and Home Health Agency Claims
P.O. Box 5700..... Prior Authorization Requests
P.O. Box 5900..... Attachments forms including Second Surgical Opinion,
Acknowledgment of Receipt of Hysterectomy Information, SURS
Referral, Oxygen & Respiratory Equipment Medical Justification
and Certificate of Medical Necessity (DME providers only)

Verizon's physical address is: Verizon Information Technologies
905 Weathered Rock Road
Jefferson City, MO 65101

SECTION 2.

CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims should be mailed to:

Verizon Information Technologies
P.O. Box 5600
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at www.dss.mo.gov/dms.

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.

Field number and name

Instructions for completion

- | | | |
|------|-----------------------------------|---|
| 1.* | Type of Health Insurance Coverage | Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a Medicaid claim is being filed, check the Medicaid box and if the patient has both Medicare and Medicaid, check both boxes. |
| 1a.* | Insured's I.D. | Enter the patient's eight-digit Medicaid or MC+ ID number (DCN) as shown on the patient's ID card. |
| 2.* | Patient's Name | Enter last name, first name, middle initial <i>in this order</i> as it appears on the ID card. |
| 3. | Patient's Birth Date Sex | Enter month, day, and year of birth. Mark appropriate box. |
| 4.** | Insured's Name | If there is individual or group insurance besides Medicaid, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank. |
| 5. | Patient's Address | Enter address and telephone number if available. |

- 6.** Patient's Relationship to Insured Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
- 7.** Insured's Address Enter the primary policyholder's address; enter policy-holder's telephone number, if available. If no private insurance is involved, leave blank.
8. Patient Status Not required.
- 9.** Other Insured's Name If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. (See Note)(1)
- 9a.** Other Insured's Policy or Group Number Enter the secondary policyholder's Insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. (See Note)(1)
- 9b.** Other Insured's Date of Birth Enter the secondary policyholder's date of birth and mark the appropriate box reflecting the sex of the secondary policyholder. If no private insurance is involved, leave blank. (See Note)(1)
- 9c.** Employer's Name Enter the secondary policyholder's employer name. If no private insurance is involved, leave blank. (See Note)(1)
- 9d.** Insurance Plan Enter the secondary policyholder's insurance plan name. If no private insurance is involved, leave blank.
- If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. (See Note)(1)*
- 10a.-10c.** Is Condition Related to: If services on the claim are related to patient's employment, an auto accident or other accident, mark the appropriate box. *If the services are not related to an accident, leave blank. (See Note)(1)*

- | | | |
|--------|--|--|
| 10d. | Reserved for Local Use | May be used for comments/descriptions. |
| 11.** | Insured's Policy or Group Number | Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. (See Note)(1) |
| 11a.** | Insured's Date of Birth | Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. (See Note)(1) |
| 11b.** | Employer's Name | Enter the primary policyholder's employer name. If no private insurance is involved, leave blank. (See Note)(1) |
| 11c.** | Insurance Plan Name | Enter the primary policyholder's insurance plan name. <i>If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. (See Note)(1)</i> |
| 11d.** | Other Health Plan | Indicate whether the patient has a secondary health insurance plan. If so, complete fields 9-9d with the secondary insurance information. (See Note)(1) |
| 12. | Patient's Signature | Leave blank. |
| 13. | Insured's Signature | This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of Medicaid. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder. |
| 14.** | Date of Current Illness, Injury or Pregnancy | This field is required when billing global prenatal and delivery services. The date |

- should reflect the last menstrual period (LMP).
15. Date Same/Similar Illness Leave blank.
16. Dates Patient Unable to Work Leave blank.
- 17.** Name of Referring Physician or Other Source Enter the name of the referring physician. If the physician is nonparticipating in the Missouri Medicaid Program, enter "nonparticipating."
- This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of "30" (radiology/radiation therapy).*
- 17a.** I.D. Number of Referring Physician Enter the referring physician's Medicaid provider number. If the physician is nonparticipating in the Missouri Medicaid Program, enter "nonparticipating."
- This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of "30" (radiology/radiation therapy).*
- 18.** Hospitalization Dates If the services on the claim were provided in an in-patient hospital setting, enter the admit and discharge dates. If the patient is still in the hospital at the time of filing, write "still" in the discharge date field or show the last date of in-patient service that is being billed in field 24a. This field is required when the service is performed on an in-patient basis.
19. Reserved for Local Use Providers may use this field for additional remarks/descriptions.
- 20.** Lab Work Performed Outside Office If billing for laboratory charges, mark the appropriate box. The referring physician may **not** bill for lab work that was referred out.
- 21.** Diagnosis Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.

- 22.** Medicaid Resubmission For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23. Prior Authorization Number Leave blank.
- 24a.* Date of Service Enter the date of service under “from” in month/day/year format, using a six-digit format. All line items **must** have a from date.
- A “to” date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days.
- 24b. Place of Service Enter the appropriate place of service code. See Section 15.10 of the Medicaid *Physician’s Provider Manual* for the list of appropriate place of service codes.
- 24c. Type of Service Leave blank.
- 24d.* Procedure Code Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered. (field 19 may be used for remarks or descriptions.)
- See Section 7 of this booklet for a list of modifiers used by the Missouri Medicaid program.
- 24e.* Diagnosis Code Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field 21.
- 24f.* Charges Enter the provider’s usual and customary charge for each line item. This should be the total charge if multiple days or units are shown.
- 24g.* Days or Units Enter the number of days or units of service provided for each detail line. The system automatically plugs a “1” if the field is left blank.
- Anesthesia—Enter the total number of minutes of anesthesia.

Consecutive visits—Subsequent hospital visits may be billed on one line if they occur on consecutive days. The days/units must reflect the total number of days shown in field 24a.

Injections—Only for those providers not billing on the Pharmacy Claim form. Enter multiple increments of the listed quantity administered. For example, if the listed quantity on the injection list is 2 cc and 4 cc are given, the quantity listed in this field is “2.”

24h.** EPSDT/Family Planning

If the service is an EPSDT/HCY screening service or referral, enter “E.” If the service is family planning related, enter “FP.” If the service is both an EPSDT/HCY and Family Planning service enter “B.”

24i. Emergency

Leave blank.

24j. COB

Leave blank.

24k.** Performing Provider Number

This field is required only for a clinic (group practice), FQHC, public health agency, teaching institution or independent radiology group. Enter the Missouri Medicaid provider number of the physician or other professional who performed the service.

25. SS#/Fed. Tax ID

Leave blank.

26. Patient Account Number

For the provider’s own information, a maximum of 12 alpha and/or numeric characters may be entered here.

27. Assignment

Not required on Medicaid claims.

28.* Total Charge

Enter the sum of the line item charges.

29.** Amount Paid

Enter the total amount received by all other insurance resources. **Previous Medicaid payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.**

30. Balance Due

Enter the difference between the total

charge (field 28) and the insurance amount paid (field 29).

31. Provider Signature

Not Required.

32.** Name and Address of Facility

If the services were rendered in a facility other than the home or office, enter the name and location of the facility.

This field is required when the place of service is other than home or office.

33.* Provider Name/ Number
/Address

Affix the provider label or write or type the information **exactly** as it appears on the label.

* These fields are mandatory on all CMS-1500 claim form.

** These fields are mandatory only in specific situations, as described.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved **leave blank**. If Medicare, Medicaid, employers name or other information appears in this field, the claim will deny. See Section 5 of the Medicaid *Provider's Manual* for further TPL (Third Party Liability) information.

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-0938-0008

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

| HEALTH INSURANCE CLAIM FORM | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> | | | | | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | | | | 3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | |
| 5. PATIENT'S ADDRESS (No., Street) | | | | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | | | | |
| 7. INSURED'S ADDRESS (No., Street) | | | | | 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE | | | | |
| 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | | | 12. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | |
| 13. EMPLOYER'S NAME OR SCHOOL NAME | | | | | 14. INSURANCE PLAN NAME OR PROGRAM NAME | | | | |
| READ BACK OF FORM BEFORE COMPLETING & SIGNING IT | | | | | | | | | |
| 15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any information to process this claim. I also request payment of government benefits either to myself or to the below. | | | | | 16. AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical benefits to the undersigned physician or supplier for services described below. | | | | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | |
| 19. RESERVED FOR LOCAL USE | | | | | 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Accident) OR PREGNANCY (LMP) | | | | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | | | | |
| 23. PRIOR AUTHORIZATION NUMBER | | | | | 24. DATE(S) OF SERVICE From MM DD YY To MM DD YY | | | | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | 26. PATIENT'S ACCOUNT NO. | | | | |
| 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 28. TOTAL CHARGE \$ | | | | |
| 29. AMOUNT PAID \$ | | | | | 30. BALANCE DUE \$ | | | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | | | | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) | | | | |
| 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # | | | | | 34. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # | | | | |

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

SECTION 3.

THE REMITTANCE ADVICE (RA)

The Remittance Advice shows claim payment or denial. If the claim has been denied or some other action taken affecting the payment, the RA lists an "Adjustment Reason Code" to explain the denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payor's reimbursement for it. The RA may also list a "Remittance Remark Code" which is from a national administrative code set for providing either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the RA pages.

Remittance advices for professional services are grouped in the following order.

- Crossover Part-B - reimbursement greater than zero
- Medical - reimbursement greater than zero
- Crossover Part-B - reimbursement equals zero
- Medical - reimbursement equals zero
- Drug
- Adjustments
- Credits

Claims in each category are listed alphabetically by the patient's last name.

| <u>FIELD NUMBER & NAME</u> | <u>EXPLANATION OF FIELD</u> |
|---------------------------------------|---|
| 1. Provider Number | The provider's 9-digit Missouri Medicaid number. |
| 2. Remittance Advice Date | The financial cycle date. |
| 3. Remittance Advice Number | The Remittance Advice number. |
| 4. Page | The Remittance Advice page number. |
| 5. Medical (Claim Type) | The type of claims(s) processed. |
| 6. Recipient Name | The patient's last name and first name. NOTE: If the patient's name and identification number are <i>not</i> on file, only the first two letters of the last name and first letter of the first name appear. |

FIELD NUMBER & NAME**EXPLANATION OF FIELD**

- | | | |
|----|-------------------------------|---|
| 7. | Medicaid I.D. | The patient's 8-digit Medicaid identification number. |
| 8. | Internal Control Number (ICN) | <p>The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim:</p> <ul style="list-style-type: none">11--Paper Drug15--Paper Medical18--Paper Medicare/Medicaid Part B Crossover Claim40--Magnetic Tape Billing (MTB) includes claims sent by Medicare intermediaries.41--Direct Electronic Medicaid Information (DEMI)43--MTB/DEMI44--Direct Electronic File Transfer (DEFT)45--Accelerated Submission and Processing (ASAP)46--Adjudicated Point of Service (POS)47--Captured Point of Service (POS)49--Internet50--Individual Adjustment Request55--Mass Adjustment70--Individual Credit to an Adjustment75--Credit Mass Adjustment <p>The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date. In a Julian system, the days of a year are numbered consecutively from "001" (January 1) to "365" (December 31) ("366" in a leap year). The last digits of an ICN are for internal processing. The ICN number 1503277316020 is read as a paper medical claim entered in the processing system on October 4, 2003.</p> <p>For a drug claim, the last digit of the ICN indicates the line number from the Pharmacy Claim form.</p> |
| 9. | Service Dates | The initial date of service in MMDDYY format followed by the final date of service in MMDDYY format. |

| <u>FIELD NUMBER & NAME</u> | <u>EXPLANATION OF FIELD</u> |
|---------------------------------------|--|
| 10. Place of Service (POS) | The 2-digit place of service. |
| 11. Proc. Code - Mod | The CPT or HCPCS procedure code, including any modifier(s) billed by the provider. |
| 12. Qty. | The units of service billed. |
| 13. Billed Amount (Charges) | The amount billed by the provider for the procedure. |
| 14. Allowed Amount (Charges) | The Medicaid maximum allowed amount for the procedure. |
| 15. Cut/Back | The difference between the billed amount and the allowed amount. |
| 16. Payment Amount | The amount Medicaid paid on the claim. |
| 17. Adjustment Reason Codes | Identifies the reasons for any differences, or adjustments, between the original provider billed amount for a claim or service and Medicaid's payment for it. |
| 18. Patient Acct | The provider's own patient account name or number. |
| 19. Remark Codes | Provides either claim level or service level messages that cannot be expressed with an Adjustment Reason Code. |
| 20. Corrected Priority Pay Name | The state is showing that there is other insurance available for the patient. When a claim denies for other insurance, the name of the commercial carrier is shown. Up to two policies can be shown. |
| 21. Other Claims Related to ID | The patient's group policy insurance number. |
| 22. Other Claims Related to ID | The patient's individual insurance policy number. |
| 23. Category Totals | Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, adjustments) has separate totals for number of claims, billed |

FIELD NUMBER & NAME**EXPLANATION OF FIELD**

amount and allowed amount. This field also includes totals for quantity, cutback and other payments, if applicable.

24. Provider Totals

Totals for this provider for this RA.

25. Spenddown Amount

Total spenddown amount(s) for this provider for this RA.

26. Earnings Data

Shows fiscal year-to-date total of claims processed and reimbursements paid to the provider.

PROVIDER NUMBER: 200000000 (1)
 MEDICAL (5)
 RECIPIENT MEDICAID
 NAME I.D. INTERNAL CONTROL NUMBER
 (6) (7) (8)

STATE OF MISSOURI MEDICAID
 REMITTANCE ADVICE AS OF 10-10-03 (2)
 SERVICE DATES FROM TO P PROC O CODE-MOD QTY BILLED AMOUNT ALLOWED AMOUNT CUT/BACK PAYMENT AMOUNT ADJUST REASON CODES
 MMDDYY MMDDYY S (9) (10) (11) (12) (13) (14) (15) (16) (17)

RA # 099999999 (3)
 PAGE 2 (4)

KROSS, IMA 09004999 1503279009999 092903 092903 11 99213 1 42.44 24.00 18.44- 24.00 A2
 PAT ACCT: KR025
 (18) 092903 092903 11 85024 1 35.00 11.70 23.30- 11.70 A2
 092903 092903 11 82948 1 18.00 1.00 17.00- 1.00 A2
 092903 092903 11 83036 1 40.00 13.41 26.59- 13.41 A2
 092903 092903 11 80061 1 50.00 18.51 31.49- 18.51 A2
 *****CLAIM TOTALS : 5 185.44 68.62 116.82- 68.62

*** REMARK CODES: N59
 (19)

JONES, MARY 05513849 4403280009898 100103 100103 11 99213 1 45.00 24.00 21.00- 24.00 A2
 PAT ACCT: JO398
 (18) 100103 100103 11 82948 1 18.00 1.00 17.00- 1.00 A2
 100103 100103 11 36415 1 4.00 .00 4.00- .00 125
 *****CLAIM TOTALS : 3 67.00 25.00 42.00- 25.00

*** REMARK CODES: N59 MA66
 (19)

SMITH, JOHN 29030841 1503279006789 100103 100103 11 99213 1 42.44 24.00 18.44- 24.00 A2
 PAT ACCT: SM145
 100103 100103 11 81003 1 12.00 .00 12.00- .00 125
 *****CLAIM TOTALS : 2 54.44 24.00 30.44- 24.00

*** REMARK CODES: MA66
 (19)

SMITH, WILL 77889911 1503279000987 100103 100103 11 99213 1 42.00 .00 42.00- .00 22
 ***REMARK CODES: MA92
 (19)

CORRECTED PRIORITY PAYER NAME: (20) DMS HEALTHCARE
 OTHER CLAIMS RELATED ID: (21) AA345678
 OTHER CLAIMS RELATED ID: (22) 555495755

*****CATEGORY TOTALS : NUMBER OF CLAIMS = 4 11 348.88 117.62 231.26- 117.62
 (23)

*****PROVIDER TOTALS : NUMBER OF CLAIMS = 4 11 348.88 117.62 231.26- 117.62
 (24)

SPENDDOWN AMOUNT: .00
 (25)

** EARNINGS DATA **
 (26) NO. OF CLAIMS PROCESSED CURRENT 75
 DOLLAR AMOUNT PROCESSED 1,752.71
 CHECK AMOUNT 1,752.71

SECTION 4. INJECTION (PHARMACY) CLAIM FILING INSTRUCTIONS

The Pharmacy Claim form should be typed or legibly printed. It may be duplicated if the copy is legible. Medicaid claims should be mailed to:

Verizon Information Technologies
P.O. Box 5400
Jefferson City, MO 65102

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

| <u>Field Number & Name</u> | <u>Instructions for Completion</u> |
|-------------------------------------|---|
| 1.* Provider Name and Number | Affix the preprinted provider label or enter the provider number, provider name and address <i>exactly</i> as it appears on the label. |
| 2.* Recipient Last Name | Enter the recipient's full last name. |
| 3.* First Name Initial | Enter the first letter of the recipient's first name. |
| 4.* Recipient Identification Number | Enter the Medicaid or MC+ number exactly as shown on the patient's ID card or approval letter. |
| 5. Nursing Home | Leave blank. |
| 6.** EPSDT | If the medication is administered as a result an EPSDT/HCY screening or referral, enter the letter "Y". Otherwise, leave blank. |
| 7.** Other Insurance | If the recipient has other insurance that covers injections, enter the letter "Y". Otherwise, leave blank. If "Y" is entered in this field, enter the name of insurance plan and the amount of the other insurance payment in field 18, Other Insurance Amount/Information. |
| 8.* Prescription Number | Enter a sequential identification number in this field. (Note: This number is used to sort claims |

submitted electronically on the remittance advice.) If the provider chooses to use a patient account number, an additional unique identifying character must be added to identify different injections administered on the same date of service. If no unique identifying character is added, all but the first claim denies as a duplicate.

9.* Prescribing Physician

Enter the Missouri State Bureau of Narcotics and Dangerous Drugs (BNDD) or the Missouri Medicaid provider number for the provider performing the service. For injections given by advanced practice nurses, nurse midwives or other applicable health care professionals, enter the BNDD number (if registered with this agency), the Missouri Medicaid Provider Number, or the BNDD of the collaborating physician. If the prescriber is not a Missouri Medicaid participant, enter the state abbreviation and phone number (without the area code) for the out-of-state provider.

10.* Date Dispensed

Enter the date the injection was administered in MM/DD/YY numeric format.

11.* National Drug Code

Enter the exact NDC assigned to the product administered as it appears on the package from which it was dispensed. Always enter the entire number, using the dotted lines to indicate where the hyphens appear, using the 5-4-2 format. If the drug code on the package is not in 5-4-2 format, enter zeroes in front of the numbers listed for each field. For example: NDC 45-143-20 must be listed 00045-0143-20.

12. Refill Code.

Leave blank.

13.* Metric Quantity

Enter the metric quantity used in administration on as follows:

Products in Solution (ampule, IV bag, bottle, syringe, vial) - bill the number of cc's (ml's) administered.

Vials Containing Powder for Reconstitution - bill the number of vials used.

Immunizations - bill the number of doses administered. (The quantity usually equals 1).
Levonorgestrel Implant - bill a quantity of 1 (1 kit = 1 unit).

- 14.* Days Supply As the process is for billing for medications administered in the physician's office, the value for this field should always equal 1. Claims with a value other than 1 in this field are denied.
15. Co-pay Amount Leave blank. Do not use this field to record insurance payments.
- 16.* Total Charge Enter the provider's usual and customary charge for this service.
- 17.* Total Amount Billed Enter the sum of the line items above.
- 18.** Other Insurance Amount/Information If payment from a private insurance company has been received, use the appropriate line number(s) of the claim(s) affected, enter the name of the insurance company and the amount of the insurance payment. If the insurance company denied payment for the service, use the appropriate line number(s) of the claim(s) affected, enter the name of the other insurance, and state "denial attached". Attach a copy of the insurance explanation of benefits documenting the reason for the denial. If the insurance denied the claim because their claim filing requirements were not met, Medicaid also denies the claim. See Section 5 of the Medicaid *Provider Manual* for further information about third party liability.
19. Remarks Leave blank.
20. Prior Authorization Number Leave blank.
21. Signature The physician or authorized representative may sign and date the form. Hand-written or computerized signatures, or a signature stamp are acceptable.

* These fields are mandatory on all Pharmacy Claim forms.

** These fields are mandatory only in specific situations, as described.

1 PROVIDER NAME AND NUMBER

MISSOURI MEDICAID PROGRAM

Pharmacy Claim

5308878

PLEASE TYPE

| LINE | 2 RECIPIENT LAST NAME | 3 FIRST NAME INITIAL | 4 RECIPIENT IDENTIFICATION NUMBER | 5 MISSING HOME Y OR X | 6 EPSDT Y OR BLANK | 7 OTHER INS. Y OR BLANK | 8 PRESCRIPTION NUMBER | 9 PRESCRIBING PHYSICIAN MEDICAID NUMBER | 10 DATE DISPENSED MM DD YY | 11 NATIONAL DRUG CODE (NDC) | 12 3000 RETAIL CODE | 13 METRIC QUANTITY | 14 DAYS SUPPLY | 15 COPAY AMOUNT | 16 TOTAL CHARGE |
|------|--------------------------|-------------------------|--------------------------------------|--------------------------|-----------------------|----------------------------|--------------------------|--|----------------------------------|--------------------------------|------------------------|-----------------------|-------------------|--------------------|--------------------|
| 0 | | | | | | | | | | | | | | | |
| 1 | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | | |

| LINE | 18 OTHER INSURANCE AMOUNT / INFORMATION | 19 REMARKS | 20 PRIOR AUTHORIZATION NUMBER | LINE | 18 OTHER INSURANCE AMOUNT / INFORMATION | 19 REMARKS | 17 TOTAL AMOUNT BILLED | 20 PRIOR AUTHORIZATION NUMBER |
|------|--|---------------|----------------------------------|------|--|---------------|---------------------------|----------------------------------|
| 0 | | | | 5 | | | | |
| 1 | | | | 6 | | | | |
| 2 | | | | 7 | | | | |
| 3 | | | | 8 | | | | |
| 4 | | | | 9 | | | | |

PHARMACY CERTIFICATION
 I CERTIFY THAT THE MEDICATION DESCRIBED ABOVE HAS BEEN DELIVERED TO THESE RECIPIENTS AND THE CHARGE(S) ON THIS CLAIM IS NO GREATER THAN THE EVERYDAY PRICE CHARGED TO THE GENERAL PUBLIC.
 I CERTIFY THAT THE SERVICES WERE PROVIDED IN COMPLIANCE WITH THE NON-DISCRIMINATION PROVISION OF TITLE VI OF THE FEDERAL CIVIL RIGHTS ACT OF 1964 AND SECTION 504 OF THE REHABILITATION ACT OF 1973.
 THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.
 PHARMACIST'S OR DISPENSING PHYSICIAN'S SIGNATURE: _____ DATE: _____

SECTION 5. INSTRUCTIONS FOR COMPLETING THE MEDICARE PART B CROSSOVER STICKER

The Medicare Part B sticker should be legibly printed by hand or electronically. Complete the Medicare Part B/Medicaid-Title XIX sticker as follows and attach it to the Medicare RA/EOMB so it does not cover the recipient's identifying information or claim payment information. Completed crossover claims should be mailed to:

Verizon Information Technologies
PO Box 5600
Jefferson City, MO 65102

| MEDICARE PART B / MEDICAID - TITLE XIX | |
|---|------------|
| Provider Name | |
| Provider Medicaid No. | |
| Recipient Name | |
| Recipient Medicaid No. | |
| Other Insurance Payment \$ | |
| Name Other Insurance Co. | |
| Patient Account No. | |
| MEDICARE INFORMATION | |
| Beneficiary HIC No. | |
| Service Date: From | Through |
| Billed \$ | Allowed \$ |
| Paid \$ | Paid Date |
| Deductible \$ | Co-Ins \$ |
| Blood Deductible \$ | |

Field number & name

Instruction for completion

- | | | |
|----|--------------------------|--|
| 1. | Provider Name | Enter the provider's name as shown on the provider label. |
| 2. | Provider Medicaid Number | Enter the provider's nine-digit Medicaid number. |
| 3. | Recipient Name | Enter the patient's name exactly as shown on the ID card. (last name, first name). |

- | | | |
|----------|--------------------------------|--|
| 4. | Recipient Medicaid Number | Enter the recipient's eight-digit identification number as shown on the ID card. |
| 5. | Other Insurance Payment | Enter the amount paid by any other insurance. Do not show the Medicare payment here. |
| 6. | Name Other Insurance Company | If an insurance amount is shown on line 5, enter name of insurance company. If the insurance plan denied payment, enter the plan name and attach a copy of the insurance denial to the claim. |
| 7. | Patient Account Number | For the provider's own information, a patient account number may be entered here. |
| 8. | Beneficiary HIC Number | Enter the patient's HIC Number as shown on the Medicare card. |
| 9. & 10. | Service Date: From and Through | Enter the date of service. If multiple dates of service are shown on the Medicare RA/EOMB for a single claim, enter the first chronological date of service in "From" field and the last chronological date of service in "Through" field. |
| 11. | Billed | Enter the total Medicare billed amount for the claim. Use the amount shown on the Medicare RA/EOMB. |
| 12. | Allowed | Enter the total Medicare allowed amount for the claim. Use the amount shown on the Medicare RA/EOMB. |
| 13. | Paid | Enter the total amount paid for the claim by Medicare. |
| 14. | Paid Date | Enter the date shown at the top of the Medicare RA/EOMB. |
| 15.* | Deductible | If any deductible was applied on this claim, enter the amount due in this field. |
| 16.* | Co-insurance | Enter the total amount of co-insurance due on this claim. |

17. Blood Deductible If there is a blood deductible due, enter that amount.

* Do not enter deductible and coinsurance amounts in the same field. They must each be listed in their own field.

MEDICARE BILLING TIPS

BILLING WHEN MEDICARE HAS A DIFFERENT PATIENT NAME THAN MEDICAID

On the paper crossover sticker, show the Medicaid name first with the Medicare name in parenthesis behind it, e.g. Smith, Roberta (Bobbi) or Jones (Masters), Gerald.

CLAIMS NOT CROSSING OVER ELECTRONICALLY

If none of a provider's Medicare claims are crossing over to Medicaid electronically, contact Medicaid to see if the provider has a Medicare number on file and that it is the correct one. Although Medicare advises that a claim was forwarded to Medicaid for processing, this does not guarantee that Medicaid received the claim information or was able to process it. If there is a problem with the claim or the recipient or provider files, the claim will not process. **A provider should wait 60 days from the date a claim was paid by Medicare before filing a crossover claim with Medicaid.** If a claim is submitted sooner, it is possible that the provider will receive a duplicate payment. If this occurs, the provider must submit an Individual Adjustment Request form to have Medicaid take back one of the payments.

TIMELY FILING

Claims initially filed with Medicare within Medicare timely filing requirements and that require separate filing of a crossover claim with Medicaid must meet the timely filing requirements by being submitted by the provider and received by the Medicaid agency within 12 months from the date of service or six months from the date on the provider's Medicare Explanation of Medicare Benefits (EOMB), whichever date is *later*. The counting of the six-month period begins with the date of adjudication of the Medicare payment and ends with the date of receipt.

BILLING FOR ELIGIBLE DAYS

A provider may attempt to bill only for eligible days on the Medicaid Part B claim form. In order for crossover claims to process correctly, a provider must bill all dates of service shown on the Medicare EOMB. The Medicaid claims system will catch those days' claims containing ineligible days and the claim will be prorated for the eligible days only.

ADJUSTMENTS

If Medicare adjusts a claim and Medicaid has paid the original crossover claim, then the original claim payment from Medicaid should be adjusted using an Individual Adjustment Request form with both Medicare EOMBs attached to the form.

SECTION 6.

MEDICARE PART B CROSSOVER CLAIM REMITTANCE ADVICE (RA)

The Medicare Part B Crossover Claim Remittance Advice shows claim payment or denial of claims that either crossed over electronically from Medicare or were filed as paper crossover claims. If the claim has been denied or some other action taken affecting the payment, the RA lists an "Adjustment Reason Code" to explain the denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payor's reimbursement for it. The RA may also list a "Remittance Remark Code" which is from a national administrative code set for providing either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the RA pages.

| <u>FIELD NUMBER & NAME</u> | <u>EXPLANATION OF FIELD</u> |
|--------------------------------|---|
| 1. Provider Number | The provider's 9-digit Missouri Medicaid number. |
| 2. Remittance Advice Date | The financial cycle date. |
| 3. Remittance Advice Number | The Remittance Advice number. |
| 4. Crossover Part B | The type of claim(s) processed. |
| 5. Page | The Remittance Advice page number. |
| 6. Recipient Name | The patient's last name and first name. NOTE: If the patient's name and identification number are <i>not</i> on file, only the first two letters of the last name and first letter of the first name appear. |
| 7. Medicaid I.D. | The patient's 8-digit Medicaid identification number (DCN). |
| 8. Patient Acct | The provider's own patient account name or number reported on the claim. |

9. ICN (Internal Control Number) The number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim:
- 11--Paper Drug
 - 15--Paper Medical
 - 18--Paper Medicare/Medicaid Part B Crossover Claim
 - 40--Magnetic Tape Billing (MTB) includes claims sent by Medicare intermediaries.
 - 41--Direct Electronic Medicaid Information (DEMI)
 - 43--MTB/DEMI
 - 44--Direct Electronic File Transfer (DEFT)
 - 45--Accelerated Submission and Processing (ASAP)
 - 47--Captured Point of Service (POS)
 - 49--Internet
 - 50--Individual Adjustment Request
 - 55--Mass Adjustment
 - 70--Individual Credit to an Adjustment
 - 75--Credit Mass Adjustment
- The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date. In a Julian system, the days of a year are numbered consecutively from "001" (January 1) to "365" (December 31) ("366" in a leap year). The last digits of an ICN are for internal processing. The ICN number 4003275316999 is read as a Medicare electronic crossover claim that was entered in the processing system on October 2, 2003.
10. Coinsurance The amount of the Medicare co-insurance, if any, due on the claim.
11. Blood Deductible The amount of the Medicare blood deductible, if any, due on the claim.
12. Deductible The amount of the Medicare deductible, if any, due on the claim.
13. From Date-Thru date The from and thru date(s) of service reported on the claim.
14. Other payments Any payment reported on the claim from another source, e.g. commercial insurance.

| | | |
|-----|---------------------|--|
| 15. | Billed Charges | The amount billed by the provider to Medicaid (e.g. co-insurance and/or deductible). |
| 16. | Allowed Charges | The Medicaid allowed amount for the billed charge(s). |
| 17. | Cutback | The difference between the billed amount and the allowed amount. |
| 18. | Payment | The amount Medicaid paid on the claim. |
| 19. | Adjust Reason Codes | Identifies the reasons for any differences, or adjustments, between the original provider billed amount for a claim or service and Medicaid's payment for it. |
| 20. | Proc Code | The CPT or HCPCS procedure code(s) billed by the provider to Medicare. |
| 21. | Modifiers | Procedure code modifiers reported on the claim to Medicare. |
| 22. | Rev Code | Not applicable to professional Part B crossover claims. |
| 23. | MCare Deduct | The Medicare deductible, if any, applied to this claim. |
| 24. | MCare Colns | The total amount of the Medicare co-insurance, if any, applied to this claim. |
| 25. | MCare Paid | The amount paid by Medicare for this claim. |
| 26. | Category Totals | Each category has separate totals for the number of claims, billed amount and allowed amount. This field also includes totals for cutback and other payments, if applicable. |
| 27. | Number of Claims | Total claims for this provider for this claim type. |
| 28. | Provider Totals | Totals for this provider for this RA. |
| 29. | Number of Claims | The number of claims reported on this RA. |
| 30. | Spenddown Amount | Total Spenddown amount(s) for this provider for this claim. |

PROVIDER NUMBER: 200000000 (1) **STATE OF MISSOURI MEDICAID** RA#1234567 (3)

CROSSOVER PART B (4) **REMITTANCE ADVICE AS OF 10-10-03 (2)** PAGE 2 (5)

| RECIPIENT NAME (6) | MEDICAID I.D. (7) | PATIENT ACCT (8) | ICN (9) | COINSURANCE (10) | BLOOD DEDUCTIBLE (11) | DEDUCTIBLE (12) |
|---------------------------|--------------------|--------------------|--------------------|------------------|-----------------------|-------------------------|
| FROM DATE-THRU DATE(13) | OTHER PAYMENTS(14) | BILLED CHARGES(15) | ALLOWED CHARGE(16) | CUT BACK(17) | PAYMENT(18) | ADJUST REASON CODES(19) |
| PROC CODE(20) | M1 M2 M3 M4 (21) | REV CODE(22) | MCARE DEDUCT(23) | MCARE COINS(24) | MCARE PAID(25) | |
| SMITH, BOB | 98765432 | X402 | 4003276009990 | \$9.03 | \$0.00 | \$0.00 |
| 07/07/03-07/07/03 | \$0.00 | \$9.03 | \$9.03 | \$0.00 | \$9.03 *** | |
| 99213 | | 000 | \$0.00 | \$9.03 | \$36.10 | |
| JO, H | 99922201 | X0032 | 4003276004999 | \$8.00 | \$0.00 | \$0.00 |
| 04/07/03-04/07/03 | \$0.00 | \$8.00 | \$0.00 | \$8.00 | \$0.00 | 140 |
| 69210 | | 000 | \$0.00 | \$8.00 | \$32.00 | |
| ****CATEGORY TOTALS: (26) | \$0.00 | \$17.03 | \$9.03 | \$8.00 | \$9.03*** | |
| NUMBER OF CLAIMS= (27) | 2 | | | | | |
| ****PROVIDER TOTALS: (28) | \$0.00 | \$17.03 | \$9.03 | \$8.00 | \$9.03*** | |
| NUMBER OF CLAIMS= (29) | 2 | | | | | |
| SPENDDOWN AMOUNT: (30) | \$0.00 | | | | | |

SECTION 7. MODIFIERS

Missouri Medicaid uses the following modifiers for the professional services. Modifiers with an asterisk following them are already in use. Others become effective on October 16, 2003.

| <u>Modifier</u> | <u>Description</u> |
|------------------------|---|
| 26 | Professional Component (required for laboratory, radiology, nuclear medicine/EEG/EKG services) |
| 50* | Bilateral Procedure |
| 52 | Reduced Services (for use only with EPSDT/HCY screening procedure codes and case management for pregnant women procedure code H1001TS52) |
| 54 | Surgical Care Only |
| 55 | Postoperative Management Only |
| 59 | Distinct Procedure Service (used only to identify the components of an EPSDT/HCY screen when only those components related to developmental and mental health are being screened) |
| 62* | Two surgeons |
| 63 | Procedure performed on infants (used only with CPT codes 99231-99233) |
| 80 | Assistant Surgeon |
| AA | Anesthesia services performed personally by anesthesiologist |
| EP | Service provided as part of Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT/HCY) program |
| QK | Medical direction of two, three or four concurrent procedures involving qualified individuals |
| QX | CRNA service, with medical direction by physician |
| QZ | CRNA service, without medical direction by physician |
| SL* | State supplied vaccine (used only with VFC administration procedure codes for dates of service March 1, 2003 and after) |
| SG | Ambulatory Surgical Center (ASC) facility services |
| TC | Technical Component (required for laboratory and radiology services) |
| TG | Complex/high level of care (for use only with procedure code T1029, Environmental Lead Assessment) |
| TS | Follow-up Service (for use only with Case Management for Children and Youth program and for Case Management for Pregnant Women program) |

The following additional level of care modifiers have been approved for use by Centers for Medicare and Medicaid Services to meet the needs of state Medicaid agencies and should not be submitted or used by any other payor.

| <u>Modifier</u> | <u>Description</u> |
|------------------------|---|
| U7 | Sexual Assault Findings Examination (SAFE) and Child Abuse Resources Examination (CARE) exams |
| U8 | Service provided in home setting (used only with CPT codes 90935 and 90945) |
| U9 | Diabetes Self-Management Training Services |
| UA | Lead related services |
| UC | EPSDT/HCY referral for follow-up care |

SECTION 8. ADJUSTMENTS

Providers who are paid incorrectly for a claim should use the *Individual Adjustment Request* form to request an adjustment. For credits only, providers may also submit individual adjustments via the Internet. Adjustments may not be requested when the net difference in payment is less than \$4.00, or \$.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the \$4.00, or \$.25, minimum limitation does not apply.

In some instances, more than one change may be necessary on a claim. **All** the changes to the claim must be addressed on the same *Individual Adjustment Request* form. Specify all the changes required, addressing each change separately. Field 15 of the form may be used to provide additional information. More than one claim **cannot** be processed per *Individual Adjustment Request* form. Each adjustment request addresses one particular claim. A separate *Individual Adjustment Request* form must be completed for each claim that requires changes, even if the changes or errors are of a similar nature or are for the same patient.

Providers submitting adjustment requests for changes in type of service codes or procedure codes must provide documentation for these changes. A copy of the original claim and the medical or operative report must be attached, along with any other information pertaining to the claim.

If an adjustment does not appear on a Remittance Advice within 90 days of submission, a copy of the original *Individual Adjustment Request* and attachments should be resubmitted. Photocopies are acceptable. Mark this copy with the word "Tracer". Submitting another request without indicating it as a "tracer" can further delay processing. Adjustments for claim credits submitted via the Internet get a confirmation back the next day after submission to confirm the acceptance and indicate the status of the adjustment. If the Internal Control Number (ICN) on the credit adjustment is not valid, the confirmation file indicates such. If no confirmation is received, the provider should resubmit the claim credit.

See Section 4 of the Medicaid *Provider Manual* for timely filing requirements for adjustments and claim resubmissions. *Individual Adjustment Requests* form are to be submitted to the address shown on the form.

A sample Individual Adjustment Request is shown on the following page.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
MISSOURI MEDICAID
INDIVIDUAL ADJUSTMENT REQUEST



UNDERPAYMENT



OVERPAYMENT

| | | | |
|--|-------------------------|---|----------------------------------|
| TO FACILITATE PROCESSING, PLEASE ATTACH THE FOLLOWING: | | FORWARD ORIGINAL TO: | |
| 1. Claim Copy 2. Remittance Advice Copy | | ATTENTION: ADJUSTMENT UNIT DIVISION OF MEDICAL SERVICES P O BOX 6500 JEFFERSON CITY MO 65102 | |
| PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE: | | | |
| 3. INTERNAL CONTROL NUMBER 1503225192499 | | 6. RECIPIENT NAME Nelson, Harriett | |
| 4. RECIPIENT MEDICAID NUMBER 12345678 | | 7. REMITTANCE ADVICE DATE 08/22/2003 | |
| 5. PROVIDER LABEL Scott, David 200000000 486 Doctors Lane Medical City, MO 60000 | | | 8. R.A. PAGE NUMBER 7 |
| REFER TO PROVIDER MANUAL ADJUSTMENT SECTION FOR INSTRUCTIONS | | | |
| | SERVICE DATE | INFORMATION ON REMITTANCE ADVICE | CORRECTED INFORMATION |
| 8. QTY/UNITS | | | |
| 9. NDC/PROCEDURE CODE | | | |
| 10. SERVICE DATE(S) | | | |
| 11. BILLED AMOUNT | | | |
| 12. PAID AMOUNT | 08/04/2003 | \$24.00 | \$0.00 |
| 13. PATIENT SURPLUS | | | |
| 14. OTHER RESOURCES (TPL) (IDENTIFY SOURCE) | | | |
| 15. OTHER/REMARKS Billed Medicaid in error. Please take back payment. | | | |
| <p align="center">HELPFUL HINTS FOR FILING AN ADJUSTMENT REQUEST FORM</p> <ol style="list-style-type: none"> Only one Internal Control Number (ICN) is allowed per adjustment request. If you want Medicaid to recoup an entire payment, do <i>not</i> enter each line of the claim. Instead, complete the top of the form and line 12 only. Enter the date of service, the amount Medicaid paid and a "0" in the corrected information field. When a change to a claim is necessary, such as a service date or quantity, use the ICN of the claim which paid and file an adjustment request. Do <i>not</i> send a new claim as it will deny as a duplicate. An ICN beginning with a 70 or 75 credits or recoups the original paid claim; an ICN beginning with a 50 or 55 repays the claim with the corrected payment information. Use the "Remarks" section of the adjustment request form to explain the reason for the correction. | | | |
| 16. PROVIDER'S SIGNATURE | | TITLE | DATE 09/30/2003 |

SECTION 9.

HEALTHY CHILDREN AND YOUTH PROGRAM

The Healthy Children and Youth (HCY) Program in Missouri is a comprehensive, primary and preventive health care program for Medicaid eligible children and youth under the age of 21 years in covered eligibility groups. The program is also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT). Medicaid covers any physical or mental illness identified by the HCY screen regardless of whether the services are covered under the state Medicaid plan. Services that are beyond the scope of the Medicaid state plan may require a plan of care identifying the treatment needs of the child with regard to amount, duration, scope and prognosis. A Prior Authorization (PA) may be required for some services.

When the initial application for public assistance is made, all qualified applicants (or his/her guardian) under age 21 are informed of the HCY program. However it is advisable for providers to notify their patients when HCY screenings are due in accordance with the following periodicity schedule:

| | | |
|--------------------|--------------|-------------|
| Newborn (2-3 days) | 15-17 months | 8-9 years |
| By 1 month | 18-23 months | 10-11 years |
| 2-3 months | 24 months | 12-13 years |
| 4-5 months | 3 years | 14-15 years |
| 6-8 months | 4 years | 16-17 years |
| 9-11 months | 5 years | 18-19 years |
| 12-14 months | 6-7 years | 20 years |

FULL SCREENING

A full screen must be performed by an enrolled Medicaid physician, nurse practitioner or nurse midwife (*only infants age 0-2 months and females age 15-20 years*) and must include all of the components listed below. If all of the components are not included, a provider cannot bill for a full screen and is to bill only for a partial screen.

- Interval History
- Unclothed Physical Examination
- Anticipatory Guidance
- Lab/Immunizations (Lab and administration of immunizations is reimbursed separately)
- Lead Assessment
- Development Personal-Social and Language
- Fine Motor/Gross Motor Skills
- Hearing
- Vision
- Dental

It is mandatory that the age appropriate *HCY Screening Guide* be used to document all components of a full or partial screen are met. The *HCY Screening Guide* is not

all-inclusive; it is to be used as a guide to identify areas of concern for each component of the HCY screen. Other pertinent information can be documented in the comment fields of the guide. **The screener must sign and date the guide and retain it in the patient's medical record.** HCY Screening Guides can be obtained by using the *Forms Request* in Section 19 or by downloading from the Internet at www.dss.mo.gov/dms.

Note: A provider cannot bill for an office visit and an HCY screen on the same date of service for a patient unless documentation in the medical record indicates a medical need for the office visit. The provider must include a "Certificate of Medical Necessity" with the claim when submitting it for payment.

DIAGNOSIS CODE FOR FULL OR PARTIAL SCREEN

For service dates prior to October 16, 2003, the "EPS" diagnosis must appear as the primary diagnosis on a claim form submitted for HCY screening services. For service dates after October 16, 2003, providers must use V20.2 as the primary diagnosis on claims for HCY screening services.

FULL SCREENING PROCEDURE CODES (New Patient)

| Proc. Code For Svc. Dates Prior To 10-16-03 | Modifier | Proc. Code For Svc. Dates After 10-16-03 (Use Age Appropriate Code) | New Modifier 1 | New Modifier 2 | Fee |
|--|----------|--|----------------------|----------------------|---------|
| W0025 | XC, XD | 99381* | 21 | EP | \$60.00 |
| W0025 | XC, XD | 99382* | 21 | EP | \$60.00 |
| W0025 | XC, XD | 99383* | 21 | EP | \$60.00 |
| W0025 | XC, XD | 99384* | 21 | EP | \$60.00 |
| W0025 | XC, XD | 99385* | 21 | EP | \$60.00 |

FULL SCREENING PROCEDURE CODES (Established Patient)

| Proc. Code For Svc. Dates Prior To 10-16-03 | Modifier | Proc. Code For Svc. Dates After 10-16-03 (Use Age Appropriate Code) | New Modifier 1 | New Modifier 2 | Fee |
|--|----------|--|----------------------|----------------------|---------|
| W0025 | XC, XD | 99391* | 21 | EP | \$60.00 |
| W0025 | XC, XD | 99392* | 21 | EP | \$60.00 |
| W0025 | XC, XD | 99393* | 21 | EP | \$60.00 |
| W0025 | XC, XD | 99394* | 21 | EP | \$60.00 |
| W0025 | XC, XD | 99395* | 21 | EP | \$60.00 |

***Modifier "UC" must be used if child was referred for further care as a result of the screening. Modifier "UC" must always appear as the last modifier.**

PARTIAL SCREENING

Different providers may provide segments of the full medical screen. The purpose of this is to increase the access to care for all children and to allow providers reimbursement for those separate screens. When expanded HCY services are accessed through a partial or interperiodic screen, it is the responsibility of the provider completing the partial screening service to have a referral source to refer the child for the remaining components of a full screening service.

PARTIAL SCREENING PROCEDURE CODES – UNCLOTHED PHYSICAL & HISTORY (New Patient)

| Proc. Code For Svc. Dates Prior To 10-16-03 | Modifier | Proc. Code For Svc. Dates After 10-16-03 (Use Age Appropriate Code) | New Modifier 1 | New Modifier 2 | Fee |
|--|----------|--|----------------------|----------------------|---------|
| W0025 | XI, XJ | 99381* | EP | | \$20.00 |
| W0025 | XI, XJ | 99382* | EP | | \$20.00 |
| W0025 | XI, XJ | 99383* | EP | | \$20.00 |
| W0025 | XI, XJ | 99384* | EP | | \$20.00 |
| W0025 | XI, XJ | 99385* | EP | | \$20.00 |

PARTIAL SCREENING PROCEDURE CODES – UNCLOTHED PHYSICAL & HISTORY (Established Patient)

| Proc. Code For Svc. Dates Prior To 10-16-03 | Modifier | Proc. Code For Svc. Dates After 10-16-03 (Use Age Appropriate Code) | New Modifier 1 | New Modifier 2 | Fee |
|--|----------|--|----------------------|----------------------|---------|
| W0025 | XI, XJ | 99391* | EP | | \$20.00 |
| W0025 | XI, XJ | 99392* | EP | | \$20.00 |
| W0025 | XI, XJ | 99393* | EP | | \$20.00 |
| W0025 | XI, XJ | 99394* | EP | | \$20.00 |
| W0025 | XI, XJ | 99395* | EP | | \$20.00 |

**Modifier "UC" must be used if child was referred for further care as a result of the screening. Modifier "UC" must always appear as the last modifier.*

PARTIAL SCREENING CODES – DENTAL

| Proc. Code For Svc. Dates Prior To 10-16-03 | Modifier | Proc. Code For Svc. Dates After 10-16-03 | New Modifier 1 | New Modifier 2 | Fee |
|--|----------|--|----------------------|----------------------|---------|
| W0025 | XK | 99429 | | | \$20.00 |
| W0025 | XL | 99429 | UC | | \$20.00 |

PARTIAL SCREENING CODES – DEVELOPMENTAL/MENTAL HEALTH

| Proc. Code For Svc. Dates Prior To 10-16-03 | Modifier | Proc. Code For Svc. Dates After 10-16-03 | New Modifier 1 | New Modifier 2 | Fee |
|--|----------|--|----------------------|----------------------|---------|
| W0025 | XE | 99429 | 59 | | \$15.00 |
| W0025 | XF | 99429 | 59 | UC | \$15.00 |

PARTIAL SCREENING CODES – HEARING

| Proc. Code For Svc. Dates Prior To 10-16-03 | Modifier | Proc. Code For Svc. Dates After 10-16-03 | New Modifier 1 | New Modifier 2 | Fee |
|--|----------|--|----------------------|----------------------|--------|
| W0025 | XP | 99429 | EP | | \$5.00 |
| W0025 | XQ | 99429 | EP | UC | \$5.00 |

PARTIAL SCREENING CODES – VISION

| Proc. Code For Svc. Dates Prior To 10-16-03 | Modifier | Proc. Code For Svc. Dates After 10-16-03 | New Modifier 1 | New Modifier 2 | Fee |
|--|----------|--|----------------------|----------------------|--------|
| W0025 | XM | 99429 | 52 | | \$5.00 |
| W0025 | XN | 99429 | 52 | UC | \$5.00 |

DESCRIPTION OF MODIFIERS USED FOR HCY SCREENINGS

- § **EP** - Service provided as part of Medicaid/MC+ early periodic, screening, diagnosis, and treatment (EPSDT).
- § **21** - Prolonged evaluation and management services. Modifier 21 must be used when completing a full HCY screen to include all ten components.
- § **52** - Reduced services. Modifier 52 must be used when all the components for the unclothed physical and history procedure codes (99381-99395) have not been met according to CPT. Also used with procedure code 99429 to identify that the components of a partial HCY vision screen have been met.
- § **59** - Distinct Service. Modifier 59 must be used to identify the components of an HCY screen when only those components related to developmental and mental health are being screened.
- § **UC** - EPSDT Referral for Follow-Up Care. The modifier UC must be used when the child is referred on for further care as a result of the screening. The modifier UC must always appear as the last modifier on the claim.

NEWBORN EXAMINATIONS

Initial newborn examinations have been identified as HCY screenings and providers **must** use either procedure code 99431 or 99432. When billing for either of these codes, Field 24h on the CMS-1500 form **must** be marked with an “E.” This indicates an EPSDT/HCY exam. The newborn’s medical record must document that **the billing provider performed all components of a full HCY examination appropriate to the child’s age and circumstances.**

DENTAL EXAMINATION

When a child receives a full HCY medical screen, it includes an oral examination that is **not** a full dental screen. A referral to a dental provider must be made where medically indicated when the child is under the age of one year. When the child is one year or older, a referral must be made, at a minimum, according to the dental periodicity schedule. Providers can instruct the recipient to call the toll free number on the back of their Medicaid/MC+ card to obtain a list of enrolled dental providers in their area or other areas of the state.

IMMUNIZATIONS

HCY screening providers are responsible for giving required immunizations. Immunizations are recommended in accordance with guidelines of the Advisory

Committee on Immunization Practices (ACIP). Immunizations must be provided during a full medical HCY screening unless medically contraindicated or refused by the parent or guardian of the patient. When an appropriate immunization is not provided, the patient's medical record must document why the appropriate immunization was not provided. If medically contraindicated, providers must follow-up to assure appropriate immunizations are provided.

Providers must use the free vaccine provided by the Missouri Department of Health and Senior Services through the Vaccine for Children (VFC) program.

To receive the free vaccine, providers must be enrolled with the Department of Health and Senior Services. Additional information on the VFC program appears later in this section.

LEAD SCREENING AND TREATMENT

All children ages six months to 72 months must be verbally screened for lead poisoning using the questions contained in the *HCY Lead Risk Assessment Guide* (use Forms Request in Section 19 to order or download from the Internet at www.dss.mo.gov/dms.) The *HCY Lead Risk Assessment Guide* is designed to allow the same document to follow the child for all visits from 6 months to 72 months of age. The guide has space on the reverse side to identify the type of blood test, venous or capillary, and also has space to identify the dates and results of blood lead levels. When an answer to any verbal question is "yes", a blood lead test must be done at that time.

Risk is determined from the response to the questions on the *HCY Lead Risk Assessment Guide*. The verbal risk assessment determines whether the child is low risk or high risk.

If the answers to all questions are negative, a child is considered low risk for high doses of lead exposure.

If the answer to any question is positive, a child is considered high risk for high doses of lead exposure.

Blood level testing is mandatory at ages 12 and 24 months.

Providers must use Medicaid's *HCY Lead Risk Assessment Guide* and retain it in the patient's medical record.

For additional information on HCY/EPSTD, providers should reference Section 9 of the provider manual at www.dss.mo.gov/dms.

PREVENTIVE MEDICINE FOR CHILDREN

Two of the key components of preventive medicine codes 99381-99395 are the history and unclothed physical examination. According to the description in CPT, an unclothed physical exam includes an age and gender history, exam, anticipatory guidance/counseling/risk factor reduction interventions (**which includes lead assessment and testing**), immunizations and lab (**which includes lead testing**). When an unclothed physical exam and history is performed for a recipient under the age of 21 years, providers should bill one of the appropriate HCY screening codes (either a full or a partial screening procedure code) referenced on previous pages.

When all the components for the history and unclothed physical examination have not been met according to CPT, providers must bill one of the codes referenced in the chart below. CPT codes 99381-99395 cannot be billed alone without a modifier for a patient under the age of 21 years.

PREVENTIVE MEDICINE CODES – REDUCED- (New Patient)

| Proc. Code For Svc. Dates Prior To 10-16-03 | Modifier | Proc. Code For Svc. Dates After 10-16-03 (Use Age Appropriate Code) | New Modifier 1 | New Modifier 2 | Fee |
|--|----------|--|----------------------|----------------------|---------|
| 99381 | | 99381 | 52 | EP | \$23.00 |
| 99382 | | 99382 | 52 | EP | \$23.00 |
| 99383 | | 99383 | 52 | EP | \$23.00 |
| 99384 | | 99384 | 52 | EP | \$23.00 |
| 99385 | | 99385 | 52 | EP | \$23.00 |

PREVENTIVE MEDICINE CODES – REDUCED – (Established Patient)

| Proc. Code For Svc. Dates Prior To 10-16-03 | Modifier | Proc. Code For Svc. Dates After 10-16-03 (Use Age Appropriate Code) | New Modifier 1 | New Modifier 2 | Fee |
|--|----------|--|----------------------|----------------------|---------|
| 99391 | | 99391 | 52 | EP | \$15.00 |
| 99392 | | 99392 | 52 | EP | \$15.00 |
| 99393 | | 99393 | 52 | EP | \$15.00 |
| 99394 | | 99394 | 52 | EP | \$15.00 |
| 99395 | | 99395 | 52 | EP | \$15.00 |

SAFE/CARE EXAMINATIONS

Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) examinations and related laboratory studies that ascertain the likelihood of sexual or physical abuse performed by SAFE trained providers certified by the Department of Health and Senior Services are covered by Medicaid. Children enrolled in a managed health care plan receive SAFE-CARE services as a benefit outside of the health plan on a fee-for-service basis. Additional information on SAFE-CARE examinations can be referenced in Section 13.15 of the physician manual located on the Internet at: www.dss.mo.gov/dms.

SAFE/CARE EXAM PROCEDURE CODES

| Proc. Code For Svc. Dates Prior To 10-16-03 | Modifier | Proc. Code For Svc. Dates After 10-16-03 | New Modifier 1 | New Modifier 2 | Fee |
|--|----------|--|----------------------|----------------------|----------|
| W1350 (SAFE) | | 99205 | U7 | | \$187.50 |
| W1350 (CARE) | WO | 99205 | U7 | 52 | \$72.50 |

Providers should reference Physician Bulletin Volume 26, Number 1, dated September 5, 2003 for other procedure codes changed for SAFE/CARE related services as a result of HIPAA.

VACCINES FOR CHILDREN (VFC) PROGRAM

Through the VFC Program, federally provided vaccine is available at no charge to public and private providers for Medicaid eligible children ages 0 through 18 years.

Medicaid requires providers who administer immunizations to qualified Medicaid eligible children to enroll in the VFC program. The VFC program is administered by the Department of Health and Senior Services. Providers should contact the DOH as follows:

Missouri Department of Health and Senior Services
Section for Communicable Disease Prevention
P.O. Box 570
Jefferson City, MO 65102
(800) 219-3224, (573) 751-6133 or facsimile at (573) 526-5220

Medicaid will pay an administration fee of \$5.00 per dose to providers to administer the free vaccine **except** to those providers enrolled as Rural Health Clinics (RHCs) or Federally Qualified Health Clinics (FQHCs). RHCs and FQHCs may bill an encounter code or appropriate level Evaluation and Management code for VFC immunizations, but **may** not bill an additional administration fee for any vaccine.

Immunizations for MC+ Recipients

MC+ health plans and their providers must use the VFC vaccine for Medicaid eligible MC+ health plan recipients. Plan providers must enroll in the program through the Department of Health and Senior Services. Providers should contact the appropriate MC+ health plan for proper billing procedures.

Immunizations Given Outside the VFC Guidelines

If an immunization is given to a Medicaid recipient who does not meet the VFC guidelines, use the standard procedure for billing injections. Physicians, clinics, and advanced practice nurse prescribers must bill injections on the Pharmacy Claim Form using the National Drug Code (NDC). The provider may bill either procedure code 90471 or 90472 for the administration of the immunization if that is the only service provided. If a significant, separately identifiable Evaluation and Management (E&M) service (codes 99201-99215) is performed, the appropriate E&M code may be billed in addition to the administration code.

FQHCs and provider based RHCs bill the CPT code for the appropriate immunization. Independent RHCs bill the encounter procedure code T1015 or T1015EP which includes all services provided during the encounter.

VFC ADMINISTRATION CODES

Effective for dates of service beginning March 1, 2003, providers must use the SL modifier for the following VFC administration codes.

For dates of service prior to March 1, 2003, providers must bill the administration codes with a “YG” modifier instead of the “SL” modifier.

| PROCEDURE CODE | DESCRIPTION | MAXIMUM ALLOWABLE |
|-----------------------|--|--------------------------|
| 90633SL | Administration of immunization; Hepatitis A vaccine, pediatric/adolescent dosage - 2 dose schedule, for intramuscular use | \$5.00 |
| 90636SL | Hepatitis A and B, adult dosage (Twinrix) | \$10.00 |
| 90645SL | Administration of immunization; Hemophilus influenza B vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use | \$5.00 |
| 90647SL | Administration of immunization; Hemophilus influenza B vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use | \$5.00 |
| 90648SL | Administration of immunization; Hemophilus influenza B vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use | \$5.00 |
| 90657SL | Administration of immunization; influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use | \$5.00 |
| 90658SL | Administration of immunization; influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use | \$5.00 |
| 90669SL | Administration of Pneumococcal; conjugate vaccine, polyvalent (Prevnar) | \$5.00 |
| 90700SL | Administration of immunization; Diphtheria, Tetanus toxoids, and Acellular Pertussis vaccine (DTaP), for intramuscular use | \$15.00 |
| 90702SL | Administration of immunization; Diphtheria and Tetanus toxoids (DT) adsorbed for pediatric use, for intramuscular use | \$10.00 |

| | | |
|---------|--|---------|
| 90707SL | Administration of immunization; Measles, Mumps and Rubella virus vaccine (MMR), live, for subcutaneous or jet injection use | \$15.00 |
| 90713SL | Administration of immunization; Polio virus vaccine, inactivated, (IPV), for subcutaneous use | \$5.00 |
| 90716SL | Administration of immunization; Varicella virus vaccine, live, for subcutaneous use | \$5.00 |
| 90718SL | Administration of immunization; Tetanus and Diphtheria toxoids (Td) adsorbed for adult use, for intramuscular or jet injection | \$10.00 |
| 90721SL | Administration of immunization; Diptheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP-Hib), for intramuscular use | \$20.00 |
| 90723SL | Pneumococcol Polysaccharide vaccine (Pediarix) | \$25.00 |
| 90732SL | Administration of immunization; Pneumococcal Polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use | \$5.00 |
| 90743SL | Administration of immunization, Hepatitis B vaccine, adolescent, muscular | \$5.00 |
| 90744SL | Administration of immunization, Hepatitis B vaccine | \$5.00 |
| 90746SL | Administration of immunization, Hepatitis B vaccine VFC Guidelines (ACIP), high risk, 0-18 years | \$5.00 |
| 90748SL | Administration of immunizations, Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use, Comvax. | \$5.00 |

SECTION 10. MATERNITY CARE AND DELIVERY

GLOBAL POLICIES

The global prenatal/delivery/postpartum fee is reimbursable when one physician or physician group practice provides all the patient's obstetric care. For this purpose, a physician group is defined as an obstetric clinic, provider type "50", there is one patient record and each physician/nurse practitioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as services occur. A primary care physician is responsible for overseeing patient care during the patient's pregnancy, delivery and postpartum care. The clinic may elect to bill globally for all prenatal, delivery and postpartum care services provided with the clinic, using the primary care physician's provider number as the performing provider.

Global prenatal care includes all prenatal visits performed at medically appropriate intervals up to the date of delivery, routine urinalysis testing during the prenatal period, care for pregnancy related conditions (e.g. nausea, vomiting, cystitis, vaginitis) and the completion of the *Risk Appraisal for Pregnant Women* form. Only one prenatal care code, 59425 (four-six visits) or 59426 (seven or more visits) may be billed per pregnancy. The date of the delivery is the date of service to be used when billing the global prenatal codes. If a provider does more than three visits but the recipient goes to another provider for the rest of her pregnancy, all visits must be billed using the appropriate office visit procedure codes.

Billing for global services cannot be done until the date of delivery.

EXEMPTED VISITS/CONSULTATIONS

A total of two visits may be reimbursed by Medicaid to the initial provider (who is not the provider of ongoing care) to establish a pregnancy, perform an initial examination, and make a referral to a second provider. For example, many recipients utilize the services of a local health agency to establish their pregnancy which then refers them elsewhere for continuing care for their pregnancy. Therefore, if the recipient sees another provider for no more than two visits for her pregnancy, the provider of ongoing care is allowed to bill global.

In addition, two consultations may be reimbursed by Medicaid to another provider. The referring provider may still bill global.

RISK APPRAISAL - CASE MANAGEMENT

As part of the global prenatal/delivery requirements, providers must complete the *Risk Appraisal for Pregnant Women* form. No additional reimbursement will be paid for the completion of the form. Any eligible woman who meets any of the risk factors listed on the form, is eligible for case management for pregnant women services and should be referred to a Medicaid enrolled participating case management provider.

NOTE - If you are not billing any of the global prenatal/delivery codes and you complete the *Risk Appraisal for Pregnant Women* form, you may bill for completion of the form using procedure code H1000.

The risk appraisal should be done during the initial prenatal visit or any time after the initial appraisal of a patient originally determined not to be at risk when changes in the patient's medical condition indicate the need.

After completing the form, remove the top two copies and mail them to the Missouri Department of Health and Senior Services. The address is preprinted on the form and no postage is required.

Risk Appraisal for Pregnant Women forms are available from the Missouri Department of Health and Senior Services at (573) 751-6215. Ask for the Prenatal Case Manager Nursing Consultant. Send form requests to: Family Health, Prenatal Care Manager Consultant, Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102.

GLOBAL OB CODES

| Code for service dates prior to 10/16/03 | Previous TOS Code | Code for service dates 10/16/03 and after | Description | Medicaid Allowable |
|--|-------------------|---|---|--------------------|
| 59400 | 2,3 | 59400 | Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and or forceps), and postpartum care. | \$1,075.00 |
| 59510 | 2 | 59510 | Routine obstetric care including antepartum care, cesarean delivery, and postpartum care | \$1,125.00 |
| 59610 | 2 | 59610 | Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps), and post partum care, after previous cesarean delivery | \$1,075.00 |
| 59618 | 2 | 59618 | Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery | \$1,125.00 |
| Y9603 | 2,3 | 59425 | Antepartum care only, 4-6 visits | \$525.00 |
| Y9603 | 2,3 | 59426 | Antepartum care only, 7 or more visits | \$525.00 |

NOTE—If you are billing for service dates prior to 10/16/03, do not bill with a type of service (TOS) unless you are billing one of the electronic formats during the HIPAA grace period as outlined in the Medicaid *Physician's Bulletin* dated 9/05/03.

Billing Tip - To avoid a denial for global delivery code 59400, 59510, 59610, or 59618, if the recipient has more than two visits, you can bill the antepartum code, 59425 or 59426, plus the appropriate delivery code. If the recipient has more than two visits, only the global antepartum will be denied.

Medicaid providers have the option to bill OB services either globally or by individual dates of service. In order to bill globally, all Medicaid guidelines must be met.

OTHER DELIVERY CODES

| Code for dates of service prior to 10/16-03 | Previous TOS Code | Code for service dates 10/16/03 and after | Description | Medicaid Allowable |
|---|-------------------|---|---|--------------------|
| 59410 | 2,3 | 59410 | Vaginal delivery (with or without episiotomy, and/or forceps) including postpartum care | \$550.00 |
| 59410 | N | 59409 | Vaginal delivery only (with or without episiotomy, and/or forceps), no post partum care | \$440.00 |
| 59410 | D | 59430 | Postpartum care only (separate procedure), vaginal delivery | \$110.00 |
| 59430 | 3 | 59430 | Postpartum care only (separate procedure) | \$110.00 |
| 59515 | 2 | 59515 | Cesarean delivery including postpartum care | \$600.00 |
| 59515 | N | 59514 | Cesarean delivery only, no post partum care | \$480.00 |
| 59515 | D | 59430 | Postpartum care only (separate procedure), cesarean delivery | \$110.00 |
| --N/A-- | --N/A-- | 59612 | Vaginal delivery only, after previous cesarean delivery, (with or without episiotomy and/or forceps) | \$440.00 |
| --N/A-- | --N/A-- | 59614 | Vaginal delivery only, after previous cesarean delivery, with our without episiotomy and/or forceps), including postpartum care | \$550.00 |
| --N/A-- | --N/A-- | 59620 | Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery. | \$480.00 |
| --N/A-- | --N/A-- | 59622 | Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care | \$600.00 |

OTHER BILLING REQUIREMENTS

- All claims with global and delivery procedure codes must show the date of the last menstrual period (LMP) in Field 14 on the CMS-1500 claim form.
- If billing a global delivery code or other delivery code, use a delivery diagnosis on the claim, e.g., 650, 669.70, etc.
- If billing a global prenatal code, 59425 or 59426, or other prenatal services, a pregnancy diagnosis, e.g., V22.0, V22.1, etc. is required on the claim.

QUESTIONS AND ANSWERS

The following are questions concerning global OB that are most frequently asked by providers and directed to the Medicaid staff.

Can Medicaid be billed by the same provider for the initial visit in the office for the pregnancy in addition to billing global?

No, all care related to the pregnancy is included in global. The only exception would be if the patient is under the age of 21 and a Healthy Children and Youth (HCY) screen was performed at the initial visit. If this is the case, the provider may bill the HCY screen using V20.2 for the primary diagnosis and a pregnancy diagnosis for the second diagnosis. Then as long as the provider meets all other global o.b. guidelines, the global o.b. codes may be billed as well.

Can the start up of a pitocin drip be billed separately?

No, Medicaid may not be billed for the start up of a pitocin drip. Not only is this procedure included in the global o.b. billing, it is also included in the delivery code if not billing global.

Can obstetrical ultrasounds be billed separately?

Yes, you may bill for ultrasounds when the ultrasounds are medically necessary. Obstetrical ultrasounds are limited to three per calendar year per recipient. If more than three are necessary, the claim must be accompanied by a properly completed Medical Necessity Form documenting the necessity of the procedure. Only one ultrasound is allowed per day. If it is medically necessary to perform a repeat ultrasound on the same day, refer to the CPT for follow-up or repeat procedures.

If the Medicaid patient has received care for her pregnancy by a provider on three different occasions, can another provider still bill global if they have met all the global guidelines?

No, the recipient is allowed two visits to a provider to establish the pregnancy and obtain a referral. If more than two visits to another provider have been reimbursed by Medicaid, the provider of ongoing care must bill out all services separately, i.e., office visits, each urinalysis, hospital visits, delivery, etc.

WILL YOUR PATIENT BE IN A MC+ HEALTH PLAN?

Depending on the area of the state, it is quite possible many of your patients may be required to enroll in a MC+ health plan and choose a primary care provider. Once a patient is enrolled in a MC+ health plan, payment for covered services becomes the responsibility of the health plan. Providers are encouraged to contact health plans to become enrolled as a MC+ provider with the plans.

If a patient becomes enrolled in a MC+ health plan in her third trimester of pregnancy, she may elect to continue to receive her obstetrical services from an out-of-plan provider. The out-of-plan provider must contact the appropriate health plan for instructions. If the out-of-plan provider only has admitting privileges in an out-of-plan hospital, the health plan is obligated to negotiate with the hospital on an agreeable reimbursement schedule.

When a patient receives more than two prenatal visits in a fee-for-service setting and transitions into a MC+ health plan and changes providers, neither provider may bill for a global OB service. In this situation, both providers must bill for each date of service using the appropriate CPT code.

When the obstetrical care begins as fee-for-service and continues with the same provider into a MC+ health plan, the provider must bill for date specific services for each program (Missouri Medicaid and the MC+ health plan). The provider cannot submit a claim for global OB care to either program.

TEMPORARY MEDICAID DURING PREGNANCY (TEMP), MEDICAL ELIGIBILITY (ME) CODE 58 OR 59

The purpose of the Temporary Medicaid During Pregnancy (TEMP) Program is to provide pregnant women with access to prenatal care while they await the formal determination of Medicaid eligibility.

TEMP services for pregnant women are limited to ambulatory physician, clinic, nurse-midwife, diagnostic laboratory, x-ray, pharmacy, and outpatient hospital services. Services other than those listed above may be covered with the attachment of a *Certificate of Medical Necessity* that testifies that the pregnancy would have been adversely affected without the service.

The diagnosis on the claim form **must** be a pregnancy/prenatal diagnosis (V22.0 through V23.9 or V28 through V28.9). Nurse midwives must use diagnosis codes V22.0 through V22.2 or V28 through V28.9.

Inpatient hospital services and deliveries performed either inpatient or outpatient are *not* covered under the TEMP program. Other non-covered services include postpartum care; contraceptive management; D & C; treatment of spontaneous, missed abortions or other abortions.

Infants born to mothers who are eligible under the TEMP Program are **not** automatically eligible under this program.

ABORTIONS AND MISCARRIAGES

Missouri Medicaid does **not** cover elective abortion services.

Any claim with a diagnosis of miscarriage, or missed or spontaneous abortion, codes 632, 634.00-634.92, 635.00-635.92, 636-636.92 and 639-639.9, must be submitted on a paper CMS-1500 claim form with all appropriate documentation attached. The documentation should include the operative report, an ultrasound, the pathology report, the admit and discharge summary, etc. to show that this was not an elective abortion.

The above information is required also when submitting a claim with one of the following procedure codes: 59200, 59812, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, or 59866.

STERILIZATIONS

A Sterilization Consent form (a copy of the form is in the forms section of this publication) is a required attachment for all claims containing the following procedure codes: 55250, 58600, 58605, 58611, 58615, 58670 and 58671. **The Medicaid recipient must be at least 21 years of age at the time the consent is obtained and be mentally competent.** The recipient must have given informed consent voluntarily in accord with Federal and State requirements.

The Sterilization Consent Form must be completed and signed by the recipient at least **31** days, but not more than **180** days, prior to the date of the sterilization procedure. There must be **30** days between the date of signing and the surgery date. The day after the signing is considered the first day when counting the 30 days. There are provisions for emergency situations (reference Section 10.2.E(1) of the *Medicaid Provider Manual* available on the internet at www.dss.mo.gov/dms).

Essure - The Essure procedure is a new permanent birth control alternative without incisions into the abdomen and any sutures or long postoperative recovery period. Essure is a device that is inserted into each fallopian tube which once incorporated into the fallopian tube, causes a localized tissue reaction. The body tissue grows into the micro-inserts, blocking the fallopian tubes.

Missouri Medicaid covers the Essure procedure in the inpatient or outpatient hospital setting only with procedure code 58615 until a specific procedure code is available. The *Sterilization Consent* form must be completed and signed at least 30 days prior to the sterilization.

SERVICES FOR WOMEN FOLLOWING THE END OF PREGNANCY-MEDICAL ELIGIBILITY (ME) CODE "80"

Services for ME "80" are limited to family planning, and testing and treatment of Sexually Transmitted Diseases (STDs) and are provided on a fee-for-service basis only. The treatments of medical complications occurring from the STD are **not** covered for this program. The co-pay requirement does not apply to ME code "80".

Covered Procedure Codes For ME "80"

| <u>Procedure Code</u> | <u>Description</u> |
|---|--|
| A4260 | Levonorgestrel (Norplant) (FQHC & provider-based RHC only) |
| A4261 | Cervical cap (invoice required with claim) |
| A4266 | Diaphragm (invoice required with claim) |
| J1055 | Injection - Medroxyprogesterone acetate, 150 mg (FQHC & provider- based RHC only) |
| J7300 | IUD (invoice required with claim) |
| J7302 | Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG (FQHC and provider-based RHC only) |
| Q0111 | Wet mounts (PPMP CLIA List) |
| T1015 | Rural health clinic encounter (independent RHC) |
| 11975 | Insertion Norplant |
| 11976 | Removal Norplant |
| 11977 | Removal with reinsertion - Norplant |
| 58300 | Insertion IUD |
| 58600 | Ligation or transection of fallopian tubes |
| 58605 | Ligation or transection of fallopian tubes, postpartum |
| 58611 | Ligation or transection of fallopian tubes, at time of C-section |
| 58615 | Occlusion of fallopian tubes by device |
| 58670 | Laparoscopy with fulguration of oviducts |
| 58671 | Laparoscopy with occlusion of oviducts by device |
| 99070 | Supplies & materials over and above those usually Included with office visit |
| 99201-99215 | Evaluation and management office/outpatient procedures |
| Lab procedures - Pap tests, tests to identify a STD, urinalysis, and blood work related to family planning or STDs. | |

Medically necessary diagnostic imaging

Covered Diagnosis Codes For ME "80"

| | |
|----------------------|---|
| V25-V25.9 | Encounter For Contraceptive Mgt |
| V72.3 | Gynecological Exam |
| V73.8-V73.88 | Other Specified Viral and Chlamydial Diseases |
| V73.9-V73.98 | Unspecified Viral and Chlamydial Disease |
| V74.5 | Venereal Disease |
| 054.1-054.19 | Genital Herpes |
| 091-091.2, 092-092.9 | Syphilis |
| 098-098.19 | Gonococcal Infections |
| 099-099.9 | Other Venereal Diseases |

Covered Birth Control Products

| | |
|-----------------------|-----------------------------|
| Progestational Agents | Contraceptives, Implantable |
| Contraceptives, Oral | Contraceptives, Injectable |

Drugs Used To Treat STDs

| | | | |
|---------------------|------------------------|-------------|-------------------------|
| Keratolytics | Aminoglycosides | Penicillins | Absorbable Sulfonamides |
| Vaginal Antifungals | Antifungal Agents | Probenecid | Tetracyclines |
| Vaginal Antibiotics | Topical Antiparasitics | Macrolides | Lincosamides |
| Topical Antivirals | Cephalosporins | Quinolones | Antivirals, General |

SECTION 11.

FAMILY PLANNING SERVICES

Family planning is defined as any medically approved diagnosis, treatment, counseling, drug, supply, or device prescribed or furnished by a provider to individuals of child-bearing age to enable such individuals to freely determine the number and spacing of their children.

When billing family planning services, providers must:

- Use a diagnosis code in the range of V25 through V25.9; and
- Enter “FP” in field 24H on the CMS-1500 or the appropriate field if billing electronically.

COVERED SERVICES

A provider may bill as a family planning service the appropriate office visit code which includes one or more of the following services.

- obtaining a medical history
- a pelvic examination
- the preparation of smears such as a Pap Smear
Note: Obtaining a specimen for a Pap smear is included in the office visit. Screening and interpretation of a Pap smear can be reimbursed only to a clinic or certified independent laboratory employing an approved pathologist, or to an individual pathologist.
- a breast examination
- All laboratory and x-ray services provided as part of a family planning encounter are payable as family planning services.
- A pregnancy test would be family planning related if provided at the time at which family planning services are initiated for an individual, at points after the initiation of family planning services where the patient may not have properly used the particular family planning method, or when the patient is having an unusual response to the family planning method.
- HIV blood screening testing performed as part of a package of screening testing and counseling provided to women and men in conjunction with a family planning encounter is reimbursable as a family planning service.

INTRAUTERINE DEVICE (IUD)

The fee for procedure code 58300 covers insertion of the IUD. Procedure code J7300, Intrauterine Copper Contraceptive, should be billed for the purchase of the IUD. A copy of the invoice indicating the type and cost must be attached to the claim for manual pricing.

The appropriate office visit procedure code may be billed for the removal of the IUD. (Procedure code 58301 is not a billable procedure as payment for the service is included in the office visit procedure code.)

DIAPHRAGMS OR CERVICAL CAPS

The fitting of a diaphragm or cervical cap is included in the fee for an office visit procedure code. The cost of the diaphragm can be billed using procedure code A4266. The cost of the cervical cap can be billed using procedure code A4261. An invoice indicating the type and cost of the items must be sent with claims for these services for manual pricing.

NORPLANT SYSTEM

The following procedure codes are for insertion only, removal only, or removal with reinsertion only and do not include reimbursement for the device.

11975 - insertion, implantable contraceptive capsules

11976 - removal, implantable contraceptive capsules

11977 - removal, implantable contraceptive capsules with reinsertion

All providers except Federally Qualified Health Centers (FQHCs), provider-based Rural Health Clinics (RHCs) and hospitals (outpatient services), must bill the Norplant device on the Pharmacy Claim form using the package NDC number. FQHCs and provider-based RHCs must bill procedure code A4260 for the Norplant device.

An office visit code may not be billed in addition to any of the Norplant procedure codes.

DEPO-PROVERA INJECTIONS

Depo-Provera injections should be billed on the Pharmacy Claim Form using the National Drug Code (NDC). FQHCs bill the injection on the CMS-1500 claim form using the appropriate injection "J" code. Provider based RHCs bill the injection on the UB-92 using the appropriate "J" code.

SECTION 12. SURGERY

PROCEDURE CODES

Missouri Medicaid recognizes the CPT and HCPCS surgery procedure codes and follows the code descriptions listed in the current editions of the publications when reviewing claims. Specific knowledge of the procedures and services performed by the physician is vital in assigning the proper CPT and HCPCS codes. Systems should be in place to correctly transmit information between the physician and the coder.

SURGICAL MODIFIERS

Missouri Medicaid uses the following CPT modifiers for surgical procedures.

- 50 - bilateral procedure
- 54 - surgical care only
- 55 - post operative management only
- 62 - two surgeons
- 80 - assistant surgeon
- SG- Ambulatory Surgical Center only (facility services)

POST-OPERATIVE CARE

Post-operative care includes 30 days of routine follow-up care for those surgical procedures having a Medicaid reimbursement amount of \$75.00 or more. For counting purposes, the date of surgery is the first day.

This policy applies whether the procedure was performed in the hospital, an ambulatory surgical center or an office setting, and applies to subsequent physician visits in any setting (e.g., inpatient and outpatient hospital, office, home, nursing home, etc.).

There is no post-operative period associated with burns or endoscopy procedures.

Supplies necessary for providing follow-up care in the office, such as splints, casts and surgical dressings in connection with covered surgical procedures, may be billed under the appropriate office supply code. See Section 14 for the list of office supply codes.

INCIDENTAL/SEPARATE SURGICAL PROCEDURES

Surgeries considered incidental to, or a part of another procedure, performed on the same day, are **not** paid separately, but rather are included in the fee for the major procedure. Determine if the surgery is considered incidental by asking yourself if it is a necessary part of the surgery or was the surgery “incidentally” performed, e.g. a laparoscopy that precedes a laparotomy. For information on procedures that are not paid when incidental to other specified services, see Section 13.42 of the Medicaid *Physician Provider Manual*.

Separate procedures are defined as a service performed independently of, and is not immediately related to other services. When performed alone, for specific and documented purposes, it may be reported. The procedure should not be billed unless it is performed by itself or is not immediately related to other services being performed during the same session.

MULTIPLE SURGICAL PROCEDURES

Multiple surgical procedures performed on the same recipient, on the same date of service, by the same provider for the same or separate body systems through separate incisions are to be billed out separately for each procedure. The important factor in coding multiple surgical procedures is to list the surgeries in order of importance or significance for payment, not necessarily always listing the most time consuming procedure first. Claims for multiple surgeries are reimbursed according to the following:

- 100% of the allowable fee for the major procedure
- 50% of the allowable fee for the secondary procedure
- 25% of the allowable fee for the third procedure

An operative report should always accompany claims with multiple surgical procedures on the same recipient on the same date of service.

CO-SURGERY

“Co-Surgeons” are defined as two primary surgeons working simultaneously performing distinct parts of a total surgical service, during the same operative session. Each physician should submit separate claims, using his/her own individual/clinic Medicaid provider number. The surgical procedure code together with modifier “62” should be shown on both claims. The name of both surgeons must appear on the claim form in the “description” area (field 24d on the CMS-1500), with a description of the entire (total) procedure performed. An operative report must be attached to each claim and the operative report should justify the necessity of two surgeons. These claims cannot be billed electronically and are manually priced by the medical consultant.

CONSULTATIONS

A consultation is when a physician renders an opinion or advice at the request of another physician. It is **not** a referral of a patient to another physician for care and treatment. A consultation must always include a written report sent back to the requesting physician. The written report must include all findings, the opinion of the consulting physician and advice or recommendations for patient treatment. When a consulting physician begins to “treat” rather than advise on treating, then it ceases to be a consultation. At that time, the consulting physician becomes an attending physician for the patient and should use appropriate levels of service codes based on the place of service. Consultation procedure codes are listed on the following page.

CONSULTATION CODES**Office/Outpatient Consult Codes**

99241
 99242
 99243
 99244
 99245 (requires a copy of the consult
 report with the claim)

In-patient Consult Codes

99251
 99252
 99253
 99254
 99255 (requires a copy of the consult
 report with the claim)

Follow-up inpatient consultations (CPT codes 99261-99263) are visits to complete the initial consultation or subsequent visits requested by the attending physician.

SECOND SURGICAL OPINION

The intent of the Second Surgical Opinion Program is to provide an eligible Missouri Medicaid patient with a second opinion as to the medical necessity of certain elective surgical operations. When the second opinion has been obtained, regardless of whether or not it confirms the primary recommendation for surgery, the final decision to undergo or forego elective surgery remains with the Medicaid patient. A list of the procedure codes requiring a second surgical opinion appears later in this section.

The Second Surgical Opinion form contains four sections and must be completed in the following manner:

Section I This section is completed by the physician recommending surgery. The appointment date in this section must be the date the patient was seen by the physician recommending surgery.

Section II Completed by the second opinion physician. A second opinion must be obtained within **60 days** after the primary recommendation appointment date in Section I of the form. When rendering a second opinion, the physician should bill a procedure code in the range of 99271-99274.

Section III Completed by the third opinion physician. A third opinion must be obtained within **60 days** after the second opinion appointment date in Section II. A third opinion is allowed by Missouri Medicaid if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation. When rendering a third opinion, the physician should bill a procedure code from the range 99271-99274.

Section IV Completed by the surgeon. Surgery must be performed within **150 days** of the first appointment date in Section I. Section IV should be completed and signed by the surgeon any time on or after the date of surgery. It is

the surgeon's responsibility to furnish the hospital or ambulatory surgical center with a copy of the completed second opinion form.

Staff interns, residents and nurse practitioners are **not** permitted to provide the first, second or third opinion.

Note – Anesthesiologists, assistant surgeons, independent laboratories, and independent x-ray services are exempt from the requirement to submit a copy of the Second Surgical Opinion form with a claim for services.

EXCEPTIONS TO SECOND OPINION REQUIREMENT

- Medicare/Medicaid crossover claims are exempt.
- The Second Surgical Opinion form is not required if the surgeon does not participate in the Missouri Medicaid Physician Program. This must be stated in field 19 of the CMS-1500 claim form and the physician's full name listed.
- Those surgical operations specified are exempt from the second surgical opinion requirement if any one of them is performed incidental to a more major surgical procedure that does not require a second surgical opinion.
- If the service was performed as an emergency and a second opinion could not be obtained prior to rendering the service, complete the claim form and enter "emergency" in field 19 of the CMS-1500. Attach a *Certificate of Medical Necessity* form (or other adequate documentation such as operative notes, admit or discharge summaries, etc.) to the claim. The provider must state on the *Certificate of Medical Necessity* form, in detail, the reason for the emergency provision of service.
- If the recipient was not Medicaid eligible at the time of service, but eligibility was made retroactive to the date of surgery, the provider should indicate "RETRO ELIG" in field 19 of the CMS-1500 form to indicate that the recipient was not eligible on the date of service but became eligible retroactive to that date. A letter from the Family Support Division county office must be attached to reflect eligibility dates.

SURGERY CODES THAT REQUIRE A SECOND OPINION

The following procedure codes require a second surgical opinion and the submission of a Second Surgical Opinion form. Procedure codes marked with an “*” also require the submission of an “Acknowledgment of Hysterectomy Information” form.

| | | | | | |
|------------|------------|------------|-----------|------------|----------|
| 28290 | 49491-50 | 49570 | 58260* | 63003-62 | 63048 |
| 28290-50 | 49491-62 | 46570-50 | 58260-62* | 63005 | 63048-62 |
| 28292 | 49491-6250 | 49570-62 | 58262* | 63005-62 | 63055 |
| 28292-50 | 49495 | 49570-6250 | 58262-62* | 63011 | 63055-62 |
| 28292-62 | 49495-50 | 49580 | 58263* | 63011-62 | 63056 |
| 28292-6250 | 49495-62 | 49580-62 | 58263-62* | 63012 | 63056-62 |
| 28293 | 49495-6250 | 49585 | 58267* | 63012-62 | 63057 |
| 28293-50 | 49500 | 49585-62 | 58267-62* | 63015 | 63057-62 |
| 28293-62 | 49500-50 | 49650 | 58270* | 63015-62 | 63064 |
| 28293-6250 | 49500-62 | 49650-50 | 58270-62* | 63016 | 63064-62 |
| 28296 | 49500-6250 | 49650-62 | 58275* | 63016-62 | 63066 |
| 28296-50 | 49505 | 49650-6250 | 58275-62* | 63017 | 63066-62 |
| 28296-62 | 49505-50 | 49651 | 58280* | 63017-62 | 63075 |
| 28296-6250 | 49505-62 | 49651-50 | 58280-62* | 63020 | 63075-62 |
| 28297 | 49505-6250 | 49651-62 | 58285* | 63020-50 | 63076 |
| 28297-50 | 49520 | 49651-6250 | 58285-62* | 63020-62 | 63076-62 |
| 28297-62 | 49520-50 | 49659 | 58290* | 63020-6250 | 63077 |
| 28297-6250 | 49520-62 | 49659-50 | 58290-62* | 63030 | 63077-62 |
| 28306 | 49520-6250 | 57240 | 58291* | 63030-50 | 63078 |
| 28306-62 | 49525 | 57240-62 | 58291-62* | 63030-62 | 63078-62 |
| 28308 | 49525-50 | 57250 | 58292* | 63030-6250 | 63081 |
| 28308-62 | 49525-62 | 57250-62 | 58292-62* | 63035 | 63081-62 |
| 47562 | 49525-6250 | 57260 | 58293* | 63035-50 | 63082 |
| 47562-62 | 49550 | 57260-62 | 58293-62* | 63035-62 | 63082-62 |
| 47563 | 49550-50 | 57265 | 58294* | 63035-6250 | 63085 |
| 47563-62 | 49550-62 | 58265-62 | 58294-62* | 63040 | 63085-62 |
| 47564 | 49550-6250 | 58120 | 58550* | 63040-50 | 63086 |
| 47564-62 | 49555 | 58150* | 58550-62* | 63040-62 | 63086-62 |
| 47600 | 49555-50 | 58150-62* | 58552* | 63040-6250 | 63087 |
| 47600-62 | 49555-62 | 58152* | 58552-62* | 63042 | 63087-62 |
| 47605 | 49555-6250 | 58152-62* | 58553* | 63042-50 | 63088 |
| 47605-62 | 49560 | 58180* | 58553-62* | 63042-62 | 63088-62 |
| 47610 | 49560-50 | 58180-62* | 58554* | 63042-6250 | 63090 |
| 47610-62 | 49560-62 | 58200* | 58554-62* | 63045 | 63090-62 |
| 47612 | 49560-6250 | 58200-62* | 59525* | 63045-62 | 63091 |
| 47612-62 | 49565 | 58210* | 59525-62* | 63046 | 63091-62 |
| 47620 | 49565-50 | 58210-62* | 63001 | 63046-62 | 63180 |
| 47620-62 | 49565-62 | 58240* | 63001-62 | 63047 | 63180-62 |
| 49491 | 49565-6250 | 58240-62* | 63003 | 63047-62 | 63182 |

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| | | | | | |
|----------|------------|----------|----------|------------|----------|
| 63182-62 | 63191-62 | 63196-62 | 66840 | 66852-6250 | 66984 |
| 63185 | 63191-6250 | 63197 | 66840-50 | 66920 | 66984-50 |
| 63185-62 | 63194 | 63197-62 | 66850 | 66920-50 | |
| 63190 | 63194-62 | 63198 | 66850-50 | 66920-62 | |
| 63190-62 | 63195 | 63198-62 | 66852 | 66920-6250 | |
| 63191 | 63195-62 | 63199 | 66852-50 | 66983 | |
| 63191-50 | 63196 | 63199-62 | 66852-62 | 66983-50 | |

SECTION 13. ANESTHESIA

PROCEDURE CODES

Medicaid recognizes CPT anesthesia codes 00100 - 01999.

The surgical procedure for which anesthesia services are being provided, must be a covered Medicaid service.

When the anesthesiologist or CRNA administers anesthesia for multiple surgical procedures for the same recipient on the same date of service during the same surgery, only the major procedure should be billed and the total number of minutes should be shown for all procedures.

Physicians and CRNAs may also bill for the insertion of intra-arterial lines, Swan Ganz catheters, central venous pressure lines, emergency intubation, and epidurals. These services are separately reportable when performed by the physician or CRNA using the following procedure codes.

| | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|
| 20550 | 36406 | 36510 | 62282 | 64408 | 64421 | 64510 |
| 31500 | 36410 | 36600 | 62310 | 64410 | 64425 | 64520 |
| 36000 | 36420 | 36620 | 62311 | 64412 | 64430 | 64530 |
| 36010 | 36425 | 36625 | 62318 | 64413 | 64435 | 93503 |
| 36011 | 36488 | 36660 | 62319 | 64415 | 64445 | 99100 |
| 36014 | 36489 | 36680 | 64400 | 64417 | 64450 | 99116 |
| 36400 | 36490 | 62273 | 64402 | 64418 | 64505 | 99135 |
| 36405 | 36491 | 62281 | 64405 | 64420 | 64508 | 99140 |

SUPERVISION (MEDICAL DIRECTION)

Anesthesiologists must have a provider specialty of anesthesiology to bill for medical direction of qualified and licensed Anesthesiologist Assistants (AA) and CRNAs.

Anesthesiologists must supervise at least two, but not more than four anesthetists. When the anesthesiologist and anesthetist both are involved in a single anesthesia service (supervision of only one anesthetist), the service is considered to be personally performed by the anesthesiologist. No separate payment is allowed for the CRNA and a charge for supervision is inappropriate.

MODIFIERS

The following modifiers should be used for anesthesia services.

- AA - Anesthesia services performed personally by anesthesiologist
- QK - Medical direction of two, three or four concurrent procedures involving qualified individuals
- QX - CRNA service, with medical direction by physician
- QZ - CRNA service, without medical direction by physician

ANESTHESIA BILLING TIPS

- For paper claims with dates of service **prior** to October 16, 2003, bill the surgical procedure code with the appropriate modifier (AA, QK, QX or QZ) for the service. Do **not** use a type of service code.
- Administration of local infiltration, digital block, or topical anesthesia by the operating surgeon or obstetrician is included in the surgery fee, and a separate fee for administration should not be billed.
- Local anesthesia should not be reported separately. It is included in the procedure/surgery if provided in the physician's office; if provided in an Ambulatory Surgical Center (ASC) or outpatient department of the hospital, it is included in the facility charge; if provided on an inpatient basis, it is included in the accommodation revenue code for the facility.
- There may be an occasional need for anesthesia during CT scan or MRI services as a result of medically necessary circumstances, i.e., hyperactive child, mentally retarded individual, etc. To report this service, use procedure code 01922 (unlisted diagnostic radiologic procedure) with the appropriate modifier.
- Anesthesiologist monitoring telemetry in the operating room is non-covered.
- Routine resuscitation of newborn infants is included in the fee for the administration of the obstetrical anesthesia in low-risk patients.
- Anesthesiologist and CRNA services are not covered in the recovery room.
- Pain management is considered a part of postoperative care. However, if an epidural or intrathecal catheter is specifically inserted for pain management, it can be reimbursed. If already inserted for anesthesia, no separate payment is allowed.
- Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions, or unusual risk factors. These procedures may be reported in addition to anesthesia services. The following procedures should be billed:

99100 - Anesthesia for patient of extreme age, under one year and over seventy.

99116 - Anesthesia complicated by utilization of total body hypothermia.

99135 - Anesthesia complicated by utilization of controlled hypotension.

99140 - Anesthesia complicated by emergency conditions (specify).

When billing the above procedure codes, the maximum quantity is always "1" as reimbursement is based on a fixed maximum allowable amount.

SECTION 14.

OFFICE MEDICAL SUPPLY CODES

Supplies and materials provided by the physician above those usually included with an office visit may be billed using the appropriate supply code.

| <u>PROC. CODE</u> | <u>DESCRIPTION</u> |
|------------------------------|--|
| A4214 | Normal Saline, 30 ml vial |
| A4260 | Levonorgestrel (Norplant) Device Only (FQHC and Provider-Based RHC only) |
| A4261 | Cervical Cap for Contraceptive use (invoice required for pricing) |
| A4266 | Diaphragm (invoice required for pricing) |
| A4300 | Implantable Vascular Access Portal/Catheter (Venous, Arterial, Epidural or Peritoneal) |
| A4344 | Indwelling Catheter, Foley Type, Two-Way, All Silicone |
| A4565 | Slings |
| A4570 | Splint |
| A4580 | Cast Supplies |
| A4590 | Casting (Fiberglass) |
| A4627EP | Spacer, Bag or Reservoir, with or without mask, for use with metered dose inhaler (invoice required for pricing) |
| J7300 | Intrauterine Copper Contraceptive (Invoice required for pricing) |
| L0120 | Cervical, Flexible, Non-Adjustable (Foam Collar) |
| L0140 | Cervical, Semi-Rigid, Adjustable (Plastic Collar) |
| L1825 | KO, Elastic Knee Cap |
| 99070 | Supplies and material (except eyeglasses, hearing aids) provided by the physician over and above those usually included with the office visit or other services rendered. (In Field 24D of the CMS-1500 claim form, list drugs, trays, supplies or materials provided.) (Invoice required for pricing) |

SECTION 15.

PRIOR AUTHORIZATION

Providers are required to seek prior authorization for certain specified services **before** delivery of the services. In addition to services that are available through the traditional Medicaid Program, expanded services are available to children 20 years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization.

The following general guidelines pertain to all prior authorized services.

- A Prior Authorization (PA) Request (yellow form) **must** be completed and mailed to the address in the upper right corner of the PA Request form. Providers should keep a copy of the original PA Request form, as the form is not returned to the provider.
- The provider performing the service **must** submit the PA Request form. Sufficient documentation or information **must** be included with the request to determine the medical necessity of the service.
- The service **must** be ordered by a physician, nurse practitioner, dentist, or other appropriate health care provider.
- Do **not** request prior authorization for services to be provided to an ineligible person. Authorization considers medical necessity only and does not examine eligibility.
- Expanded HCY (EPSDT) services are limited to recipients 20 years of age and under and are **not** reimbursed for recipients 21 and over even if prior authorized.
- Prior authorization does **not** guarantee payment if the recipient is or becomes enrolled in managed care and the service is a covered benefit.
- Payment is **not** made for services initiated before the approval date on the PA Request form or after the authorization deadline. For services to continue after the expiration date of an existing PA Request, a new PA Request **must** be completed and mailed.

Whether the prior authorization is approved or denied, a disposition letter will be returned to the provider containing all of the detail information related to the prior authorization request. Any other documentation submitted with the prior authorization request will not be returned with the exception of x-rays and dental molds. All requests for changes to an approved prior authorization should be indicated on the disposition letter and submitted to the same address as the original prior authorization request.

Instructions for completing the PA Request form are found in Section 8 of the Medicaid *Provider's Manual* available on the Internet at www.dss.mo.gov/dms.

PROCEDURES REQUIRING A PRIOR AUTHORIATION

The following procedure codes require a Prior Authorization Request form.

| | | | | | |
|----------|----------|----------|----------|------------|------------|
| 11920 | 15833 | 19357 | 21122 | 43847-62 | 67901-50 |
| 11920-EP | 15834 | 19357-50 | 21123 | 43848 | 67902 |
| 11921 | 15835 | 19361 | 21123-62 | 43848-62 | 67902-50 |
| 11921-EP | 15836 | 19361-50 | 21125 | 50365 | 67902-62 |
| 11922-EP | 15837 | 19364 | 21127 | 50365-50 | 67902-6250 |
| 11960 | 15838 | 19364-50 | 21127-62 | 50365-62 | 67903 |
| 11970 | 15839 | 19366 | 21188 | 50365-6250 | 67903-50 |
| 11971 | 17999-EP | 19366-50 | 21194 | 50547 | 67903-62 |
| 11981 | 19316 | 19367 | 21230 | 50547-50 | 67903-6250 |
| 11982 | 19316-50 | 19367-50 | 21235 | 50547-62 | 67904 |
| 11983 | 19318 | 19368 | 21260 | 50547-6250 | 67904-50 |
| 15780 | 19318-50 | 19368-50 | 21260-62 | 54152 | 67904-62 |
| 15781 | 19324 | 19369 | 21261 | 54161 | 67904-6250 |
| 15782 | 19324-50 | 19369-50 | 21261-62 | 54162 | 67906 |
| 15786 | 19325 | 19370 | 21720 | 54163 | 67906-50 |
| 15787 | 19325-50 | 19370-50 | 21725 | 54164 | 67908 |
| 15810 | 19328 | 19371 | 21725-62 | 56805 | 67908-50 |
| 15811 | 19328-50 | 19371-50 | 26580 | 56805-62 | 67909 |
| 15820 | 19330 | 19380 | 26590 | 57335 | 67909-50 |
| 15820-50 | 19330-50 | 19380-50 | 43659 | 57335-62 | 67923 |
| 15821 | 19340 | 20974 | 43659-50 | 58345 | 67923-50 |
| 15821-50 | 19340-50 | 21086 | 43842 | 58345-50 | 67924 |
| 15822 | 19342 | 21086-50 | 43842-62 | 58345-62 | 67924-50 |
| 15822-50 | 19342-50 | 21087 | 43843 | 58345-6250 | 69300 |
| 15823 | 19350 | 21088 | 43843-62 | 65767 | 69949-EP |
| 15823-50 | 19350-50 | 21120 | 43846 | 65767-50 | 92391-EP |
| 15831 | 19355 | 21120-62 | 43846-62 | 67900 | |
| 15832 | 19355-50 | 21121 | 43847 | 67901 | |

SECTION 16. LABORATORY SERVICES

Clinical Laboratory Improvement Act (CLIA)

CLIA Waiver Procedures

Medicaid providers possessing a Certificate of Waiver are allowed to perform the following procedures.

| | | | | |
|---------|-------|-------|-------|---------|
| 80061 | 82273 | 83002 | 85014 | 87210U7 |
| 80101 | 82274 | 83026 | 85018 | 87449 |
| 81002 | 82465 | 83036 | 85610 | 87804 |
| 81003 | 82570 | 83518 | 85651 | 87880 |
| 81007 | 82679 | 83605 | 86294 | 89300 |
| 81025 | 82947 | 83718 | 86308 | |
| 81025U7 | 82950 | 83986 | 86318 | |
| 82010 | 82951 | 84460 | 86618 | |
| 82044 | 82952 | 84478 | 86701 | |
| 82055 | 82962 | 84703 | 87072 | |
| 82120 | 82985 | 84830 | 87077 | |
| 82270 | 83001 | 85013 | 87210 | |

Physician Performed Microscopy Procedures (PPMP) --

Medicaid providers possessing a PPMP certificate are allowed to perform all the waiver procedures as well as the following additional procedures.

| | | | | |
|-------|-------|-------|-------|-------|
| Q0111 | Q0113 | Q0115 | 81001 | 81020 |
| Q0112 | Q0114 | 81000 | 81015 | 89190 |

Questions regarding CLIA registration or accreditation should be directed to:

Bureau of Health Facility Regulation
Department of Health and Senior Services
P.O. Box 570
Jefferson City, Missouri 65102-0570
(573) 751-6318

CLINICAL DIAGNOSTIC LABORATORY PROCEDURES

The following procedures have been identified as clinical diagnostic laboratory procedures and therefore, have only a technical component. The codes should be billed **without** any modifier except the "U7" modifier as noted in the following list which is used for procedures related to SAFE (Sexual Assault Forensic Examinations) services.

| | | | | | | | |
|-------|-------|---------|-------|-------|-------|-------|-------|
| P3000 | 80185 | 81001 | 82136 | 82370 | 82542 | 82696 | 82955 |
| P7001 | 80186 | 81002 | 82139 | 82373 | 82543 | 82705 | 82960 |
| Q0111 | 80188 | 81003 | 82140 | 82374 | 82544 | 82710 | 82962 |
| Q0112 | 80190 | 81005 | 82143 | 82375 | 82550 | 82715 | 82963 |
| Q0113 | 80192 | 81015 | 82145 | 82376 | 82552 | 82725 | 82965 |
| Q0114 | 80194 | 81020 | 82150 | 82378 | 82553 | 82726 | 82975 |
| Q0115 | 80196 | 81025 | 82154 | 82379 | 82554 | 82728 | 82977 |
| 80048 | 80197 | 81025U7 | 82157 | 82380 | 82565 | 82731 | 82978 |
| 80050 | 80198 | 81050 | 82160 | 82382 | 82570 | 82735 | 82979 |
| 80051 | 80200 | 81099 | 82163 | 82383 | 82575 | 82742 | 82980 |
| 80053 | 80201 | 82000 | 82164 | 82384 | 82585 | 82746 | 82985 |
| 80055 | 80202 | 82003 | 82172 | 82387 | 82595 | 82747 | 83001 |
| 80061 | 80299 | 82009 | 82175 | 82390 | 82600 | 82757 | 83002 |
| 80069 | 80400 | 82010 | 82180 | 82397 | 82607 | 82759 | 83003 |
| 80074 | 80402 | 82013 | 82190 | 82415 | 82608 | 82760 | 83008 |
| 80076 | 80406 | 82016 | 82205 | 82435 | 82615 | 82775 | 83010 |
| 80100 | 80408 | 82017 | 82232 | 82436 | 82626 | 82776 | 83012 |
| 80101 | 80410 | 82024 | 82239 | 82438 | 82627 | 82784 | 82013 |
| 80102 | 80412 | 82030 | 82240 | 82441 | 82633 | 82785 | 82014 |
| 80150 | 80414 | 82040 | 82247 | 82465 | 82634 | 82787 | 83015 |
| 80152 | 80415 | 82042 | 82248 | 82480 | 82638 | 82800 | 83018 |
| 80154 | 80416 | 82043 | 82252 | 82482 | 82646 | 82803 | 83021 |
| 80156 | 80417 | 82044 | 82261 | 82485 | 82649 | 82805 | 83026 |
| 80157 | 80418 | 82055 | 82270 | 82486 | 82651 | 82810 | 83030 |
| 80158 | 80420 | 82075 | 82273 | 82487 | 82652 | 82820 | 83033 |
| 80160 | 80422 | 82085 | 82274 | 82488 | 82654 | 82926 | 83036 |
| 80162 | 80424 | 82088 | 82286 | 82489 | 82657 | 82928 | 83045 |
| 80164 | 80426 | 82101 | 82300 | 82491 | 82658 | 82938 | 83050 |
| 80166 | 80428 | 82103 | 82306 | 82492 | 82664 | 82941 | 83051 |
| 80168 | 80430 | 82104 | 82307 | 82495 | 82666 | 82943 | 83055 |
| 80170 | 80432 | 82105 | 82308 | 82507 | 82668 | 82945 | 83060 |
| 80172 | 80434 | 82106 | 82310 | 82520 | 82670 | 82946 | 83065 |
| 80173 | 80435 | 82108 | 82330 | 82525 | 82671 | 82947 | 83068 |
| 80174 | 80436 | 82120 | 82331 | 82528 | 82672 | 82948 | 83069 |
| 80176 | 80438 | 82127 | 82340 | 82530 | 82677 | 82950 | 83070 |
| 80178 | 80439 | 82128 | 82355 | 82533 | 82679 | 82951 | 83071 |
| 80182 | 80440 | 82131 | 82360 | 82540 | 82690 | 82952 | 83080 |
| 80184 | 81000 | 82135 | 82365 | 82541 | 82693 | 82953 | 83088 |

| | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|---------|
| 83090 | 83789 | 83992 | 84220 | 84480 | 85041 | 85384 | 86038 |
| 83150 | 83805 | 84022 | 84228 | 84481 | 85044 | 85385 | 86039 |
| 83491 | 83825 | 84030 | 84233 | 84482 | 85045 | 85400 | 86060 |
| 83497 | 83835 | 84035 | 84234 | 84484 | 85046 | 85410 | 86063 |
| 83498 | 83840 | 84060 | 84235 | 84485 | 85048 | 85415 | 86140 |
| 83499 | 83857 | 84061 | 84238 | 84488 | 85049 | 85420 | 86141 |
| 83500 | 83858 | 84066 | 84244 | 84490 | 85130 | 85421 | 86146 |
| 83505 | 83864 | 84075 | 84252 | 84510 | 85170 | 85441 | 86147 |
| 83516 | 83866 | 84078 | 84255 | 84512 | 85175 | 85445 | 86148 |
| 83518 | 83872 | 84080 | 84260 | 84520 | 85210 | 85460 | 86155 |
| 83519 | 83873 | 84081 | 84270 | 84525 | 85220 | 85461 | 86156 |
| 83520 | 83874 | 84085 | 84275 | 84540 | 85230 | 85475 | 86157 |
| 83525 | 83880 | 84087 | 84285 | 84545 | 85240 | 85520 | 86160 |
| 83527 | 83883 | 84100 | 84295 | 84550 | 85244 | 85525 | 86161 |
| 83528 | 83885 | 84105 | 84300 | 84560 | 85245 | 85530 | 86162 |
| 83540 | 83887 | 84106 | 84302 | 84577 | 85246 | 85536 | 86171 |
| 83550 | 83890 | 84110 | 84305 | 84578 | 85247 | 85540 | 86185 |
| 83570 | 83891 | 84119 | 84307 | 84580 | 85250 | 85547 | 86215 |
| 83582 | 83892 | 84120 | 84311 | 84583 | 85260 | 85549 | 86225 |
| 83586 | 83893 | 84126 | 84315 | 84585 | 85270 | 85555 | 86226 |
| 83593 | 83894 | 84127 | 84375 | 84586 | 85280 | 85557 | 86235 |
| 83605 | 83896 | 84132 | 84376 | 84588 | 85290 | 85597 | 86243 |
| 83615 | 83897 | 84133 | 84377 | 84590 | 85291 | 85610 | 86255 |
| 83625 | 83898 | 84134 | 84378 | 84591 | 85292 | 85611 | 86277 |
| 83632 | 83901 | 84135 | 84379 | 84597 | 85293 | 85612 | 86280 |
| 83633 | 83902 | 84138 | 84392 | 84600 | 85300 | 85613 | 86294 |
| 83634 | 83903 | 84140 | 84402 | 84620 | 85301 | 85635 | 86300 |
| 83655 | 83904 | 84143 | 84403 | 84630 | 85302 | 85651 | 86301 |
| 83661 | 83905 | 84144 | 84425 | 84681 | 85303 | 85652 | 86304 |
| 83662 | 83906 | 84146 | 84430 | 84702 | 85305 | 85660 | 86308 |
| 83663 | 83912 | 84150 | 84432 | 84703 | 85306 | 85670 | 86309 |
| 83664 | 83915 | 84152 | 84436 | 84830 | 85307 | 85675 | 86310 |
| 83670 | 83916 | 84153 | 84437 | 84999 | 85335 | 85705 | 86316 |
| 83690 | 83918 | 84154 | 84439 | 85002 | 85337 | 85730 | 86317 |
| 83715 | 83919 | 84155 | 84442 | 85004 | 85345 | 85732 | 86317U7 |
| 83716 | 83921 | 84160 | 84443 | 85007 | 85347 | 85810 | 86318 |
| 83718 | 83925 | 84165 | 84445 | 85008 | 85348 | 85999 | 86327 |
| 83719 | 83930 | 84181 | 84446 | 85009 | 85360 | 86000 | 86329 |
| 83721 | 83935 | 84182 | 84449 | 85013 | 85362 | 86001 | 86331 |
| 83727 | 83937 | 84202 | 84450 | 85014 | 85366 | 86003 | 86332 |
| 83735 | 83945 | 84203 | 84460 | 85018 | 85370 | 86005 | 86334 |
| 83775 | 83950 | 84206 | 84466 | 85025 | 85378 | 86021 | 89336 |
| 83785 | 83970 | 84207 | 84478 | 85027 | 85379 | 86022 | 86337 |
| 83788 | 83986 | 84210 | 84479 | 85032 | 85380 | 86023 | 86340 |

| | | | | | | | |
|---------|---------|-------|-------|---------|---------|-------|---------|
| 86341 | 86638 | 86720 | 86870 | 87077 | 87253 | 87400 | 87533 |
| 86343 | 86641 | 86723 | 86880 | 87081 | 87254 | 87420 | 87534 |
| 86344 | 86644 | 86727 | 86885 | 87084 | 87255 | 87425 | 87534U7 |
| 86353 | 86645 | 86729 | 86886 | 87086 | 87260 | 87427 | 87535 |
| 86359 | 86648 | 86732 | 86890 | 87088 | 87265 | 87430 | 87535U7 |
| 86360 | 86651 | 86735 | 86891 | 87101 | 87267 | 87449 | 87536 |
| 86361 | 86652 | 86738 | 86900 | 87102 | 87270 | 87450 | 87536U7 |
| 86376 | 86653 | 86741 | 86901 | 87103 | 87271 | 87451 | 87537 |
| 86378 | 86654 | 86744 | 86903 | 87106 | 87272 | 87470 | 87537U7 |
| 86382 | 86658 | 86747 | 86904 | 87107 | 87273 | 87471 | 87538 |
| 86384 | 86663 | 86750 | 86905 | 87109 | 87274 | 87472 | 87538U7 |
| 86403 | 86664 | 86753 | 86906 | 87110 | 87275 | 87475 | 87539 |
| 86406 | 86665 | 86756 | 86920 | 87110U7 | 87276 | 87476 | 87539U7 |
| 86430 | 86666 | 86757 | 86921 | 87116 | 87277 | 87477 | 87540 |
| 86431 | 86668 | 86759 | 86922 | 87118 | 87278 | 87480 | 87541 |
| 86485 | 86671 | 86762 | 86927 | 87140 | 87279 | 87481 | 87542 |
| 86490 | 86674 | 86765 | 86930 | 87143 | 87280 | 87482 | 87550 |
| 86510 | 86677 | 86768 | 86931 | 87147 | 87281 | 87485 | 87551 |
| 86580 | 86682 | 86771 | 86932 | 87149 | 87283 | 87486 | 87552 |
| 86585 | 86684 | 86774 | 86940 | 87152 | 87285 | 87487 | 87555 |
| 86586 | 86687 | 86777 | 86941 | 87158 | 87290 | 87490 | 87556 |
| 86590 | 86687U7 | 86778 | 86945 | 87166 | 87299 | 87491 | 87557 |
| 86592 | 86688 | 86781 | 86950 | 86168 | 87300 | 87492 | 87560 |
| 86592U7 | 86688U7 | 86784 | 86965 | 87169 | 87301 | 87495 | 87561 |
| 86593 | 86689 | 86787 | 86970 | 87172 | 87320 | 87496 | 87562 |
| 86602 | 86689U7 | 86790 | 86971 | 87176 | 87324 | 87497 | 87580 |
| 86603 | 86692 | 86793 | 86972 | 87177 | 87327 | 87510 | 87581 |
| 86606 | 86694 | 86800 | 86975 | 87181 | 87328 | 87511 | 87582 |
| 86609 | 86695 | 86803 | 86976 | 87184 | 87332 | 87512 | 87590 |
| 86611 | 86696 | 86804 | 86977 | 87185 | 87335 | 87515 | 87591 |
| 86612 | 86698 | 86805 | 86978 | 87186 | 87336 | 87516 | 87592 |
| 86615 | 86701 | 86806 | 86999 | 87187 | 87337 | 87517 | 87620 |
| 86617 | 86702 | 86807 | 87001 | 87188 | 87338 | 87520 | 87621 |
| 86618 | 86703 | 86808 | 87003 | 87190 | 87339 | 87521 | 87622 |
| 86619 | 86704 | 86812 | 87015 | 87197 | 87340 | 87522 | 87650 |
| 86622 | 86705 | 86813 | 87040 | 87205 | 87341 | 87525 | 87651 |
| 86625 | 86706 | 86816 | 87045 | 87206 | 87350 | 87526 | 87652 |
| 86628 | 86707 | 86817 | 87046 | 87210 | 87380 | 87527 | 87797 |
| 86631 | 86708 | 86821 | 87070 | 87210U7 | 87385 | 87528 | 87798 |
| 86631U7 | 86709 | 86822 | 87071 | 87220 | 87390 | 87529 | 87799 |
| 86632 | 86710 | 86849 | 87073 | 87230 | 87390U7 | 87530 | 87800 |
| 86632U7 | 86713 | 86850 | 87075 | 87250 | 87391 | 87531 | 87801 |
| 86635 | 86717 | 86860 | 87076 | 87252 | 87391U7 | 87532 | 87802 |

| | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|
| 87803 | 87999 | 88154 | 88235 | 88263 | 88283 | 89050 | 89321 |
| 87804 | 88130 | 88155 | 88237 | 88264 | 88285 | 89051 | 89325 |
| 87810 | 88140 | 88164 | 88239 | 88267 | 88289 | 89055 | 89330 |
| 87850 | 88142 | 87165 | 88240 | 88269 | 88349 | 89060 | 89350 |
| 87880 | 88143 | 88166 | 88241 | 88271 | 88355 | 89125 | 89355 |
| 87899 | 88147 | 88167 | 88245 | 88272 | 88356 | 89160 | 89360 |
| 87901 | 88148 | 88174 | 88248 | 88273 | 88358 | 89190 | 89365 |
| 87902 | 88150 | 88175 | 88249 | 88274 | 88371 | 89300 | |
| 87903 | 88152 | 88230 | 88261 | 88275 | 88372 | 89310 | |
| 87904 | 88153 | 88233 | 88262 | 88280 | 88400 | 89320 | |

SECTION 17. RESOURCE PUBLICATIONS FOR PROVIDERS

CURRENT PROCEDURE TERMINOLOGY (CPT)

Missouri Medicaid uses the latest version of the *Current Procedural Terminology* (CPT). All provider offices should obtain and refer to the CPT book to assure proper coding. Providers can order a CPT book from the American Medical Association.

Order Department
American Medical Association
PO Box 7046
Dover, DE 19903-7046
Telephone Number: 800/621-8335
Fax Orders: 312/464-5600

ICD-9-CM

The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9) is the publication used for proper diagnostic coding. The diagnosis code is a required field on certain claim forms and the accuracy of the code that describes the patient's condition is important. The publication can be ordered from the following source.

Ingenix Publications
PO Box 27116
Salt Lake City, UT 84127-0116
800/464-3649
Fax Orders: 801/982-4033
www.IngenixOnline.com

HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS)

Medicaid also uses the *Health Care Procedure Coding System (HCPCS), National Level II*. It is a listing of codes and descriptive terminology used for reporting the provision of supplies, materials, injections and certain services and procedures. The publication can be ordered from the following.

Practice Management Information Corporation
4727 Wilshire Blvd. Ste 300
Los Angeles, CA 90010
800/633-7467
<http://pmiconline.com>

SECTION 18.

RECIPIENT LIABILITY

State Regulation 13CSR 70-4.030

If an enrolled Medicaid provider does not want to accept Missouri Medicaid as payment but instead wants the patient (recipient) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that Medicaid will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The agreement must be done prior to the service(s) being rendered.** A copy of the agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to Medicaid for reimbursement for the covered service(s).

If Medicaid denies payment for a service because all policies, rules and regulations of the Missouri Medicaid program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before Medicaid is billed.

MEDICAID RECIPIENT REIMBURSEMENT (MMR)

The Medicaid Recipient Reimbursement program (MMR) is devised to make payment to those recipients whose eligibility for Medicaid benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Recipients are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The recipient is furnished with special forms to have completed by the provider(s) of service. If Medicaid recipients have any questions, they should call (800) 392-2161.

SECTION 19. FORMS

On the following pages are copies of various forms used by the Missouri Medicaid program.

Certain Medicaid programs, services and supplies require the submission of a form before a claim can be processed for payment. Please note that several of the forms can be submitted electronically through the Verizon Internet service at

www.emomed.com.

Acknowledgement of Receipt of Hysterectomy Information
Second Surgical Opinion
Sterilization Consent

If a form is submitted electronically, the provider **must** keep a paper copy of the form in the patient's medical record.

Copies of the forms are available from Medicaid from the following sources.

- Contact the Provider Communications Unit at 800/392-0938 or 573/751-2896.
- Go to the Medicaid website, www.dss.mo.gov/dms, and select and click on the link to the Missouri Medicaid Provider Manuals.
- Use the Verizon order form found at the end of this section.

MO-8812

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____
(doctor or clinic) When I first asked for

the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT AND NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
Month Day Year

I, _____, hereby consent
of my own free will to be sterilized by _____
(doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature Date Month Day Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- | | |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black (not of Hispanic origin) |
| <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> Hispanic |
| | <input type="checkbox"/> White (not of Hispanic origin) |

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter Date

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
name of individual

consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent Date

Facility

Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

Name of individual to be sterilized Medicalaid number

on _____, I explained to him/her the nature of the
Date of sterilization

sterilization operation _____, the fact that
specify type of operation

it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested).

- ☐ Premature delivery
☐ Individual's expected date of delivery:
☐ Emergency abdominal surgery:
(describe circumstances):

Physician

Medicalaid provider number Date



MISSOURI DEPARTMENT OF HEALTH
RISK APPRAISAL FOR PREGNANT WOMEN

INSTRUCTIONS ON REVERSE SIDE

| | | | |
|--|---|---|---|
| DCN OR TEMP. NO | BIRTHDATE (MM/DD/YY) | DATE OF RISK APPRAISAL | PROVIDER NAME (ATTACH MEDICAID PROVIDER LABEL) |
| CLIENT'S NAME (LAST, FIRST, MI, MAIDEN) | | | ADDRESS (STREET) |
| ADDRESS (STREET) | | | CITY STATE ZIP CODE |
| CITY | STATE | ZIP CODE | MEDICAID PROVIDER NUMBER |
| TELEPHONE NUMBER () | COUNTY OF RESIDENCE | MARITAL STATUS CODE <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP | MONTH PRENATAL CARE BEGAN <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 |
| RACE/ETHNICITY <input type="checkbox"/> 1. WHITE <input type="checkbox"/> 2. BLACK <input type="checkbox"/> 3. AM.IND/ALASKAN <input type="checkbox"/> 4. ASIAN/PACIFIC ISLANDER <input type="checkbox"/> 5. OTHER | HISPANIC ORIGIN <input type="checkbox"/> YES <input type="checkbox"/> NO | LMP (MM/DD/YY) | GRAVIDA PARA ABORTA |

PUT AN "X" IN ALL THE BOXES BELOW THAT APPLY. AN "X" IN ANY ONE OF THE FIRST 34 RISK FACTOR BOXES QUALIFIES CLIENT FOR CASE MANAGEMENT SERVICES.

| | |
|--|--|
| <input type="checkbox"/> 1. Mother's age 17 years of less at time of conception. <input type="checkbox"/> 2. Mother's education less than 8 years. <input type="checkbox"/> 3. Gravida greater than or equal to 7. <input type="checkbox"/> 4. Smoking equal to or greater than one pack of cigarettes per day, IF CLIENT HAS STOPPED SMOKING BY THE 12TH WEEK OF GESTATION, CONSIDER AS NON SMOKING. <input type="checkbox"/> 5. Mother's age 40 years or greater at time of conception. <input type="checkbox"/> 6. Prepregnancy weight less than 100 lbs. <input type="checkbox"/> 7. Previous fetal death (20 weeks gestation or later). <input type="checkbox"/> 8. Previous infant death. <input type="checkbox"/> 9. History of incompetent cervix in current or past pregnancy. <input type="checkbox"/> 10. History of diabetes mellitus including gestational diabetes in current or past pregnancy. <input type="checkbox"/> 11. Multiple fetuses in current pregnancy. <input type="checkbox"/> 12. Pre-existing hypertension (a history of hypertension — 140/90 mm Hg or greater — antedating pregnancy or discovery of hypertension — 140/90 or greater — before the 20th week of pregnancy). <input type="checkbox"/> 13. Pregnancy-induced hypertension in current pregnancy (blood pressure is 140/90 or greater, or there has been an increase of 30 mm Hg systolic or 15 mm Hg diastolic over baseline values on at least two occasions six or more hours apart). <input type="checkbox"/> 14. Prior low birth weight baby (<2500 grams or 5 lbs. 8 oz.). | <input type="checkbox"/> 15. Prior preterm labor (<37 completed weeks gestation). <input type="checkbox"/> 16. Preterm labor: current pregnancy. <input type="checkbox"/> 17. Seropositive for HIV antibodies. <input type="checkbox"/> 18. Interconceptional spacing <1 year. <input type="checkbox"/> 19. Living alone or single parent living alone. <input type="checkbox"/> 20. Considered relinquishment of infant. <input type="checkbox"/> 21. Poor environmental conditions. <input type="checkbox"/> 22. Late entry into care (after 4th month or 18 weeks gestation). <input type="checkbox"/> 23. Homelessness. <input type="checkbox"/> 24. Alcohol abuse by client. <input type="checkbox"/> 25. Alcohol abuse by partner. <input type="checkbox"/> 26. Drug dependence or misuse by client. <input type="checkbox"/> 27. Drug dependence or misuse by partner. <input type="checkbox"/> 28. Physical or emotional abuse/neglect of client. <input type="checkbox"/> 29. Physical abuse of children in the home. <input type="checkbox"/> 30. Neglect of children in the home. <input type="checkbox"/> 31. Partner with history of violence. <input type="checkbox"/> 32. Chronic or recent mental illness and/or psychiatric treatment. <input type="checkbox"/> 33. Elevated blood lead level 15ug/dl or greater. <input type="checkbox"/> 34. Other, identify: _____ <input type="checkbox"/> 99. None of the above. |
|--|--|

FOLLOWING DOES NOT QUALIFY FOR CASE MANAGEMENT SERVICES. DATA COLLECTION IS NECESSARY FOR PROGRAM PLANNING. (CHECK ONE)

| | |
|---|--|
| <input type="checkbox"/> 1. Intended pregnancy. <input type="checkbox"/> 2. Unintended pregnancy using birth control | <input type="checkbox"/> 3. Unintended pregnancy not using birth control. <input type="checkbox"/> 4. Unintended pregnancy - birth control unknown. |
|---|--|

| | | |
|--|----------------------------------|--|
| SPECIFY GESTATIONAL AGE AT TIME OF RISK APPRAISAL: WEEKS | APPROXIMATE DUE DATE MM DD YY | PHYSICIAN'S PERFORMING PROVIDER NUMBER |
| PROVIDER SIGNATURE | DATE | |
| PREFERRED CASE MANAGEMENT PROVIDER AGENCY | | |



MISSOURI MEDICAID CERTIFICATE OF MEDICAL NECESSITY

| | | | | |
|--------------------------------------|--------------------------------|-----------------------------|---|--|
| Patient Name | | | Medicaid ID Number | |
| TOS | Procedure Codes (Maximum 6) | Description of Item/Service | Reason for Service | Months Equip. Needed (DME only): |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| Attending/Prescribing Physician Name | | | Attending/Prescribing Physician Medicaid Number | |
| Date Prescribed | | | Diagnosis | Prognosis |
| Provider Name and Address | | | Provider Medicaid Number | |
| Provider Signature | | | | |

MO-8813

PLEASE SUBMIT THIS FORM FOR EACH PROCEDURE
REQUIRING DOCUMENTATION OF MEDICAL NECESSITY

DS1960 (09/01/02)



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
EXCEPTIONS UNIT
MEDICAID EXCEPTION REQUEST

RETURN TO: ATTN EXCEPTIONS UNIT
DIVISION OF MEDICAL SERVICES
PO BOX 6500
JEFFERSON CITY MO 65102-6500
FAX NO: 573-522-3061

| ALL INFORMATION MUST BE SUPPLIED OR THE REQUEST WILL BE RETURNED | |
|---|----------------------------|
| FOR LIFE THREATENING EMERGENCIES CALL 1-800-392-8030 | |
| PLEASE TYPE OR PRINT | |
| RECIPIENT NAME | DATE OF BIRTH |
| RECIPIENT MEDICAID NUMBER (DCN) | SOCIAL SECURITY NUMBER |
| RECIPIENT DIAGNOSES (MUST RELATE TO ITEM(S) OR SERVICE(S) REQUESTED) | |
| <hr/> <hr/> <hr/> <hr/> | |
| LIST ALL APPROPRIATE ALTERNATIVE COVERED SERVICES ATTEMPTED AND FOUND INEFFECTIVE FOR THIS DIAGNOSIS. | |
| <hr/> <hr/> <hr/> <hr/> | |
| REQUESTED ITEM(S) OR SERVICE(S) (INCLUDING DAILY QUANTITY) | |
| <hr/> <hr/> <hr/> <hr/> | |
| DURATION OF NEED | |
| MISSOURI MEDICAID PROVIDER WHO WILL BE DISPENSING AND BILLING FOR SERVICES (EX. DME PROVIDER) | |
| NAME | TELEPHONE NUMBER |
| ADDRESS | PROVIDER NUMBER (IF KNOWN) |
| IS A HOME HEALTH AGENCY MAKING SKILLED NURSE VISITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | AGENCY NAME |
| PRINT OR TYPE DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE | TELEPHONE NUMBER |
| PRINT OR TYPE DOCTOR'S ADDRESS OR APN'S ADDRESS | FAX NUMBER |
| DOCTOR'S ORIGINAL SIGNATURE, OR APN'S ORIGINAL SIGNATURE AND TITLE (NO STAMPS OR PHOTOCOPIES) | DATE |

MO 886-3351 (3-02)



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
MISSOURI MEDICAID INSURANCE RESOURCE REPORT

TPL-4

Submit this form to notify the Medicaid agency of insurance information that you have verified for a Medicaid recipient. Please send the completed form to:

Department of Social Services
Division of Medical Services
Attention: TPL Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

DO NOT SEND CLAIMS WITH THIS FORM. YOUR CLAIM WILL NOT BE PROCESSED FOR PAYMENT IF ATTACHED TO THIS FORM.

PROVIDER IDENTIFICATION NUMBER

DATE (MM / DD / YY)

PROVIDER NAME

CHECK THE APPROPRIATE BOX FOR THE REQUESTED ACTION



ADD NEW RESOURCE

OR



CHANGE MEDICAID RESOURCE FILES

RECIPIENT NAME

MEDICAID I.D. NUMBER

INSURANCE COMPANY NAME

POLICYHOLDER (IF OTHER THAN RECIPIENT)

POLICYHOLDER'S SOCIAL SECURITY NUMBER

POLICY NUMBER

GROUP NAME OR NUMBER

VERIFIED INFORMATION

SOURCE OF VERIFIED INFORMATION:

☐ EMPLOYER☐ INSURANCE COMPANY

TELEPHONE NUMBER OF CONTACT

DATE CONTACTED (MM / DD / YY)

()

NAME OF PERSON COMPLETING THIS FORM

TELEPHONE NUMBER

Do you want confirmation of this add/update?

(If yes, you must complete the name and address on back)

☐ YES☐ NO**ATTACH A COPY OF AN EXPLANATION OF BENEFITS OR INSURANCE LETTER IF AVAILABLE**

TO BE COMPLETED BY THE PROVIDER

If confirmation of this add/update is requested, please write the name and address of the person the confirmation should be sent to below. The TPL Unit will complete the bottom portion of this form and mail to the address shown.

TO BE COMPLETED BY THE STATE

☐ Verification and correction as requested completed Date: _____

Insurance Begin Date: _____ Insurance End Date: _____

☐ Please resubmit claims

☐ Form not complete enough for verification by state - complete highlighted areas and resubmit

☐ TPL file already reflects the add/update. Our records were updated: _____

☐ Verification confirms Medicaid resource file correct as is - no update performed

☐ Change requested cannot be made. Reason:

☐ Verification shows another current coverage that may be applicable:

☐ Other: _____



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
PRIOR AUTHORIZATION REQUEST

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the equipment or prosthesis is received by the recipient. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

I. GENERAL INFORMATION

| | | |
|---|-----------------------------|--------------------------|
| 1. NAME (LAST, FIRST, M.I.) | 2. NAME (LAST, FIRST, M.I.) | 3. DATE OF BIRTH |
| 4. ADDRESS (STREET, CITY, STATE, ZIP CODE) | | 5. MEDICAID NUMBER |
| 6. PROGNOSIS | 7. DIAGNOSIS CODE | 8. DIAGNOSIS DESCRIPTION |
| 9. NAME & ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE. | | |

II. HCY (EPSDT) SERVICE REQUEST**(MAY REQUIRE PLAN OF CARE)**

| | | |
|-----------------------------|--|--------------------------------|
| 10. DATE OF HCY SCREEN | 11. SCREENING <input type="checkbox"/> FULL <input type="checkbox"/> INTERPERIODIC <input type="checkbox"/> PARTIAL | 12. TYPE OF PARTIAL HCY SCREEN |
| 13. SCREENING PROVIDER NAME | 14. PROVIDER NUMBER | 15. TELEPHONE NUMBER () |

III. SERVICE INFORMATION**(DO NOT WRITE IN SHADED AREAS)****FOR STATE USE ONLY**

| 16. REF. NO. | 17. TYPE SERV. | 18. PROCEDURE CODE | 19. FROM | 20. THROUGH | 21. DESCRIPTION OF SERVICE/ITEM | 22. QTY. OR UNITS | 23. AMOUNT TO BE CHARGED | APPR. | DENIED | AMOUNT ALLOWED IF PRICED BY REPORT |
|--------------|----------------|--------------------|----------|-------------|---------------------------------|-------------------|--------------------------|-------|--------|------------------------------------|
| (1) | | | | | | | | | | |
| (2) | | | | | | | | | | |
| (3) | | | | | | | | | | |
| (4) | | | | | | | | | | |
| (5) | | | | | | | | | | |
| (6) | | | | | | | | | | |
| (7) | | | | | | | | | | |
| (8) | | | | | | | | | | |
| (9) | | | | | | | | | | |
| (10) | | | | | | | | | | |
| (11) | | | | | | | | | | |
| (12) | | | | | | | | | | |

24. DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES/EQUIPMENT/PROCEDURE/PROSTHESIS (ATTACH ADDITIONAL PAGES IF NECESSARY)

IV. PROVIDER

| |
|--------------------------------------|
| 25. PROVIDER NAME (AFFIX LABEL HERE) |
| 26. ADDRESS |
| 27. MEDICAID PROVIDER NUMBER |
| 28. SIGNATURE |
| DATE |

V. PRESCRIBING/PERFORMING PRACTITIONER

| | |
|--|--------------------------------------|
| 29. NAME | 30. TELEPHONE () |
| 31. ADDRESS | |
| 32. DATE DISABILITY BEGAN | 33. PERIOD OF MEDICAL NEED IN MONTHS |
| I certify that the information given in Sections I and III of this form is true, accurate, and complete. | |
| 34. SIGNATURE OF PRESCRIBING PHYSICIAN/PRACTITIONER | DATE |

VI. FOR STATE OFFICE USE ONLY

DENIAL REASON(S): REFER TO FIELD 16 ABOVE BY REFERENCE NUMBERS (REF. NO.)

| | | |
|---|------|-------------------------|
| IF APPROVED: services authorized to begin | DATE | REVIEWED BY SIGNATURE ► |
|---|------|-------------------------|

INSTRUCTIONS FOR COMPLETION

I. GENERAL INFORMATION – To be completed by the provider requesting the prior authorization.

1. Leave Blank
2. Recipients Name – Enter the recipient's name as it appears on the Medicaid ID card. Enter the recipients current address.
3. Date of Birth – Enter the recipient's date of birth.
4. Address – Enter the recipients address, city, state, and zip.
5. Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.
6. Prognosis – Enter the recipients prognosis.
7. Diagnosis Code – Enter the diagnosis code(s).
8. Diagnosis Description – Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
9. Name and address of the facility where services are to be rendered if service is to be provided other than home or office.

II. HCY SERVICE REQUEST (Plan of care may be required, see your provider manual)

10. Date of HCY Screen – Enter the date the HCY Screen was done.
11. Screening -Check whether the screening performed was FULL, INTERPERIODIC, or PARTIAL.
12. Type of Partial HCY Screen – Enter the type of partial HCY Screen that was performed. (e.g., Vision, Hearing, etc.)
13. Screening Provider Name – Enter the provider's name who performed the screening.
14. Provider Number – Enter the provider's number who performed the screening.
15. Telephone Number – Enter the screening provider's telephone number including the area code.

III. SERVICE INFORMATION

16. Ref. No. = (Reference Number) A unique designator (1-12) identifying each separate line on the request.
17. Type of Service – Enter the appropriate type of service code for each procedure code.
18. Procedure Code – Enter the procedure code(s) for the services being requested.
19. From – Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
20. Through – Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
21. Description of Service/Item – Enter a specific description of the service/item being requested.
22. Quantity or Units – Enter the quantity or units of service/item being requested.
23. Amount to be Charged – Enter the amount to be charged for the service.
24. Detailed Explanation of Medical Necessity of the service, equipment/prosthesis, etc. Attach additional page(s) as necessary.
Do not use another Prior Authorization Form.

IV. PROVIDER REQUESTING PRIOR AUTHORIZATION

25. Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.
26. Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.
27. Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid Identification number.
28. Signature/Date -The provider of services should sign the request and indicate the date the form was completed.
(Check your provider manual to determine if this field is required.)

V. PRESCRIBING/PERFORMING PRACTITIONER

This section must be completed for services which require a prescription such as Durable Medical Equipment, Physical Therapy, or for services which will be prescribed by a physician/practitioner that require Prior Authorization. Check your provider manual for additional instructions.

29. Name – Enter the name of the prescribing/performing/practitioner.
30. Telephone Number – Enter the prescribing/performing/practitioner telephone number including area code.
31. Address – Enter the address, city, state, and zip code.
32. Date Disability Began – Enter the date the disability began. For example, if a disability originated at birth, enter date of birth.
33. Period of Medical Need in Months – Enter the estimated number of months the recipient will need the equipment/services.
34. Signature of prescribing/performing/practitioner-The prescribing physician/practitioner must sign and indicate the date signed in mm/dd/yy format. **(Signature stamps are not acceptable)**

VI. FOR STATE OFFICE USE ONLY

Approval or denial for each line will be indicated in the box to the right of Section III. Also in this box the consultant will indicate allowed amount if procedure requires manual pricing.

At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 12). The consultant will sign or initial the form.



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
MISSOURI MEDICAID ACCIDENT REPORT

Submit this form to notify the Medicaid agency of information you have regarding a Medicaid recipient's accident or injury. Please send the completed form to:

Department of Social Services
Division of Medical Services
Attention: TPL Casualty/Tort Recovery
P.O. Box 6500
Jefferson City, Missouri 65102-6500

DO NOT send claims with this form. Your claims will not be processed for payment if attached to this form.

| | | | |
|---|--|---------------------|--|
| PROVIDER IDENTIFICATION NUMBER | | DATE (MM/DD/YY) | |
| PROVIDER NAME | | DATES OF SERVICE | |
| RECIPIENT NAME | | MEDICAID NUMBER | |
| DATE OF ACCIDENT/INJURY | | APPROXIMATE TIME | |
| TYPE OF ACCIDENT/INJURY <input type="checkbox"/> AUTO <input type="checkbox"/> WORK-RELATED <input type="checkbox"/> OTHER (EXPLAIN) | | | |
| ATTORNEY REPRESENTING RECIPIENT | | | |
| RESPONSIBLE PARTY'S NAME | | POLICY/CLAIM NUMBER | |
| INSURANCE COMPANY NAME AND ADDRESS | | | |
| HAVE YOU FILED A LIEN? IF YES, PLEASE PROVIDE DETAILS (I.E., AMOUNT, SERVICE DATES, ETC.) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| REMARKS | | | |
| Please attach copies of relevant documents (i.e. letters from attorneys, insurance companies, etc.) if applicable. THANK YOU FOR YOUR ASSISTANCE. | | | |



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

APPLICATION FOR PROVIDER DIRECT DEPOSIT

PLEASE TYPE OR PRINT IN BLACK INK

SEE INSTRUCTIONS ON REVERSE SIDE

SECTION A (All providers must complete this section)

1. TYPE OF DIRECT DEPOSIT ACTION ➡ ☐ New provider/Re-enrollment ♦ ☐ Cancel Direct Deposit ♦ ☐ Change Account/Route number

2. PROVIDER NAME: Complete provider name below as shown on provider labels. If the Application for Provider Direct Deposit is for a clinic or group, this form must be accompanied by an Authorization by Clinic Members which must contain a list of the provider name(s) and number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic/group, along with the ORIGINAL signature of the clinic owner or administrator. All other providers MUST complete a separate Application for Provider Direct Deposit containing their individual provider number and original signature. The clinic Application for Provider Direct Deposit will not be processed without the completed Authorization by Clinic Members. A separate Application for Provider Direct Deposit must be completed for each provider number assigned.

TYPE OR PRINT PROVIDER NAME HERE ➡

3. PROVIDER NUMBER (enter provider number as shown on provider label, one provider number per application)

SECTION B (Complete this section if you wish to enroll in direct deposit OR a change in account/route number(s) is requested.)
(ATTACH a voided check showing the routing/account numbers, OR if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution completed below. The information completed on this form and the information on the attachment MUST match.)

1. ROUTING NUMBER

2. DEPOSITOR ACCOUNT NUMBER

3. TYPE OF ACCOUNT (must check one) ➡ ☐ CHECKING ♦ ☐ SAVINGS

4. FINANCIAL INSTITUTION NAME

5. BRANCH NUMBER OR NAME (if applicable)

6. FINANCIAL INSTITUTION ADDRESS

7. TELEPHONE NUMBER (include area code)

SECTION C

I wish to participate in Direct Deposit and in doing so:

- ♦ I understand that in endorsing or depositing checks that payment will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State laws.
- ♦ I hereby authorize the State of Missouri to initiate credit entries (deposits) and to initiate, if necessary, debit entries (withdrawals) or adjustments for any credit entries made in error to my account designated above.
- ♦ I understand that the State of Missouri may terminate my enrollment in the Direct Deposit program if the State is legally obligated to withhold part or all payments for any reason.
- ♦ I understand that the Division of Medical Services may terminate my enrollment if I no longer meet the eligibility requirements.
- ♦ I understand that this document shall not constitute an amendment or assignment, of any nature whatsoever, of any contract, purchase order or obligation that I may have with an agency of the State of Missouri.

I am authorized to request Direct Deposit on behalf of this clinic/group and in doing so:

- ♦ I acknowledge that each individual in the clinic/group listed on the attached Authorization by Clinic Members has been informed of this request, and also informed that Medicaid funds will be sent to the depositor account specified above.
- ♦ I understand that each individual provider is responsible for all services provided and all billing done under the individual or clinic provider number, regardless to whom the reimbursement is paid. It is each individual provider's responsibility to use the proper billing code and indicate the length of time actually spent providing a service, regardless to whom the reimbursement is paid.

1. ☐ I HEREBY CANCEL MY DIRECT DEPOSIT AUTHORIZATION and authorize future payments to be sent to the current payment name and address recorded in the provider enrollment file. (Section A number 1 must also be completed)

2. PROVIDER ORIGINAL SIGNATURE
(see requirements on reverse side of this form)

TYPE OR PRINT
NAME SIGNED & TITLE

3. DATE

4. TELEPHONE NUMBER

RETURN ORIGINAL FORM (and original Authorization by Clinic Members, if applicable) ALONG WITH A VOIDED CHECK OR LETTER FROM YOUR BANK (see Section B) TO: Division of Medical Services, Provider Enrollment Unit, PO Box 6500, Jefferson City MO 65102. Phone 573-751-2617

THIS FORM CANNOT BE FAXED

APPLICATION FOR PROVIDER DIRECT DEPOSIT INSTRUCTIONS

SECTION A ***ALL providers must complete this section***

1. **Type of Direct Deposit Action** - Check appropriate box. **If canceling direct deposit you must also complete Section C, #1.**
 2. & 3. **Provider Name and Provider Number** - Enter provider name and number **EXACTLY** as shown on your provider label.

SECTION B ***This section must be complete for new applicants or re-enrollments and any changes to your direct deposit information.

ATTACH a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form**. The information completed on this form and the information on the attachment **MUST** match.

1. **Routing Number** - Enter your financial institution's routing number as printed on the bottom left portion of your business checks or deposit tickets (the first 9 digits). See Examples 1 and 2 below.
2. **Depositor Account Number** - Enter depositor account number as printed on the bottom of business checks following the routing number. It may be the first series of digits after the routing number followed by your check number (example 1) or it may be the series of digits which follow your check number (example 2). NOTE: The check number is not included in the depositor account number.

EXAMPLE 1

| | | |
|--|---------------|----------------|
| FINANCIAL INSTITUTION HOMETOWN, USA | | CHECK NO. 4444 |
| PAY TO ORDER OF _____ | | |
| 121456789 | 8765432109812 | 4444 |

EXAMPLE 2

| | | |
|--|------|---------------|
| FINANCIAL INSTITUTION HOMETOWN, USA | | CHECK 4444 |
| PAY TO ORDER OF _____ | | |
| 121456789 | 4444 | 8765432109812 |

| | | | | | |
|-------------|--------------------|-----------|-------------|-----------|--------------------|
| ↑↓ | ↑↓ | ↑↓ | ↑↓ | ↑↓ | ↑↓ |
| Routing No. | Depositor Acct No. | Check No. | Routing No. | Check No. | Depositor Acct No. |

*****Credit Unions and Savings and Loan Associations may differ from the above examples. Please VERIFY your DEPOSITOR ACCOUNT NUMBER and ELECTRONIC ROUTING NUMBER with your financial institution.*****

SECTION C

1. **TO CANCEL OR REDESIGNATE:** Complete and submit a new Application for Provider Direct Deposit with the changed information and forward to the Division of Medical Services. **You must check the CANCEL box if you wish to CANCEL your direct deposit, Section A number 1 must also be completed.** If you elect to cancel direct deposit future payments will be sent to the current payment name and address recorded in the provider enrollment file. Provider direct deposits will continue to be deposited into the designated account at your financial institution until the Division of Medical Services is notified that you wish to **cancel or redesignate** your account and/or financial institution.
DO NOT CLOSE AN OLD ACCOUNT UNTIL THE FIRST PAYMENT IS DEPOSITED INTO YOUR NEW ACCOUNT.
2. **PROVIDER SIGNATURE** - If the provider is enrolled as an individual, he/she must sign the form. Nursing homes, hospitals, independent laboratories and home health agencies must be signed by a person listed on form HCFA-1513 (disclosure of ownership) section III (a). If enrolled as a clinic or business (except those listed above) the form must be signed by the person with fiscal responsibility for the same. **Clinic applications must be accompanied by the Authorization by Clinic Members which must contain a list of the name(s) and provider number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic location. The Application for Provider Direct Deposit and the Authorization by Clinic Members MUST be signed by the same person. All other providers must complete a separate Application for Provider Direct Deposit containing their individual provider number and original signature. A SEPARATE FORM MUST BE COMPLETED FOR EACH PROVIDER NUMBER ASSIGNED.**

OTHER

1. **ATTACH** a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form**. The information completed on this form and the information on the attachment **MUST** match.
2. Direct deposit will be initiated after a properly completed application form is approved by the Division of Medical Services and the successful processing of a test transaction through the banking system.
3. **This form must be used to change** any financial institution information **or to cancel** your election to participate in direct deposit.
4. The Division of Medical Services will terminate or suspend the direct deposit option for administrative or legal actions including, but not limited to, ownership change, duly executed liens or levies, legal judgements, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider and closure or abandonment of an account.
5. If any information completed on this form cannot be verified from the attachments or the form is completed incorrectly, the form(s) will be returned without being processed for direct deposit.

**MISSOURI MEDICAID
SECOND SURGICAL OPINION FORM**

PLEASE PRINT OR TYPE

SECTION I: TO BE COMPLETED BY PRIMARY (FIRST OPINION) PHYSICIAN

MO-8807

| | | | | |
|---|---|-----------------|---------------------------------------|-------------------|
| RECIPIENT'S NAME (FIRST) (M.I.) (LAST) | | | RECIPIENT'S MEDICAID I.D. NUMBER | |
| SURGICAL PROCEDURE DISCUSSED & RECOMMENDED | | CPT-4 PROCEDURE | CODES | ICD-9-CM DX. CODE |
| PERTINENT HISTORY SYMPTOMS AND PHYSICAL FINDINGS | | | | |
| PHYSICIAN'S NAME (FIRST) (MI) (LAST) | | | Physician's Mo. Medicaid Provider No. | |
| PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code) | | | SPECIALITY, IF APPLICABLE | |
| APPOINTMENT DATE | PERSONAL SIGNATURE OF PRIMARY PHYSICIAN (NAME) (DATE) | | | |

REFER THIS FORM TO THE SECOND OPINION PHYSICIAN WITH RESULTS OF PATIENT'S HISTORY AND PHYSICAL REPORT, LABORATORY DATA, X-RAYS, ETC. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION II: TO BE COMPLETED BY SECOND SURGICAL OPINION PHYSICIAN

| | | | | |
|--|--|-----------------------|---------------------------------------|--|
| NEED FOR SURGERY <input type="checkbox"/> CONFIRMED <input type="checkbox"/> NOT CONFIRMED | STATE REMARKS: | | | |
| SURGICAL PROCEDURE RECOMMENDED, IF SURGERY CONFIRMED | | CPT-4 PROCEDURE CODES | ICD-9-CM DX. CODE | |
| SECOND OPINION PHYSICIAN'S NAME (FIRST) (M.I.) (LAST) | | | Physician's Mo. Medicaid Provider No. | |
| SECOND OPINION PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code) | | | SPECIALITY, IF APPLICABLE | |
| APPOINTMENT DATE | PERSONAL SIGNATURE OF SECOND OPINION PHYSICIAN (NAME) (DATE) | | | |

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN REFERENCED IN SECTION I. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION III: TO BE COMPLETED BY THIRD SURGICAL OPINION PHYSICIAN

(A third surgical opinion is covered by Mo. Medicaid only if the second surgical opinion physician did not recommend surgery)

| | | | | |
|--|---|-----------------------|---------------------------------------|--|
| NEED FOR SURGERY <input type="checkbox"/> CONFIRMED <input type="checkbox"/> NOT CONFIRMED | STATE REMARKS: | | | |
| SURGICAL PROCEDURE RECOMMENDED, IF SURGERY CONFIRMED | | CPT-4 PROCEDURE CODES | ICD-9-CM DX. CODE | |
| THIRD OPINION PHYSICIAN'S NAME (FIRST) (M.I.) (LAST) | | | Physician's Mo. Medicaid Provider No. | |
| THIRD OPINION PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code) | | | SPECIALITY, IF APPLICABLE | |
| APPOINTMENT DATE | PERSONAL SIGNATURE OF THIRD OPINION PHYSICIAN (NAME) (DATE) | | | |

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN REFERENCED IN SECTION I. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION IV: TO BE COMPLETED BY SURGEON, IF SURGERY IS PERFORMED AT REQUEST OF RECIPIENT

| | | | |
|---|--|---------------------------------------|--|
| SURGICAL PROCEDURE PERFORMED | | CPT-4 PROCEDURE CODES | |
| ICD-9-CM DX. CODE | SPECIFY NAME AND ADDRESS OF SURGERY SITE | | |
| DATE OF SURGERY | | | |
| SURGEON'S NAME (FIRST) (M.I.) (LAST) | | Physician's Mo. Medicaid Provider No. | |
| SURGEON'S OFFICE ADDRESS (Street) (City) (State) (Zip Code) | | SPECIALITY, IF APPLICABLE | |
| PERSONAL SIGNATURE OF SURGEON (NAME) (DATE) | | | |

THE SURGEON MUST ATTACH THIS COMPLETED SECOND SURGICAL OPINION FORM TO HIS MEDICAID CLAIM FOR THE SURGICAL PROCEDURE. IT IS THE SURGEON'S RESPONSIBILITY TO FURNISH A COPY OF THIS COMPLETED FORM TO THE HOSPITAL/ AMBULATORY SURGICAL CARE CENTER, IN ORDER THAT THE FACILITY MAY BILL MEDICAID FOR RELATED CHARGES. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.

DS1907 (02/01)



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

This form must be completed when a hysterectomy is to be performed which is not precluded from Medicaid reimbursement under Federal regulatory provisions at 42 CFR 441.255(a) and which is not exempted from the requirement for this documentation under provisions at 42 CFR 441.255(d) or (e).

The requirement for Acknowledgement of Receipt of Hysterectomy Information applies to an individual of any age. The form must be signed by the recipient or her representative, if any, prior to the surgery. Hysterectomies for family planning purposes are not payable through Medicaid or any other federally funded program, nor from the general relief or blind pension programs.

| | | |
|---|-------------------------------|-----------------------------|
| 1. NAME OF RECIPIENT | 2. MEDICAID ID NUMBER | 3. NAME OF REPRESENTATIVE |
| 1. SOURCE OF HYSTERECTOMY INFORMATION | | |
| PART I | | |
| TO BE COMPLETED BY THE PERSON WHO SECURES THE AUTHORIZATION TO PERFORM THE HYSTERECTOMY | | |
| 5. I certify that I have informed the above named recipient and her representative, if any, orally and in writing , that the hysterectomy will render her permanently incapable of reproducing. I further certify that the purpose for performing the hysterectomy is: | | |
| 3. SIGNATURE AND TITLE OF PERSON SECURING AUTHORIZATION | | 7. DATE (MONTH/DAY/YEAR) |
| 3. PHYSICIAN / CLINIC NAME | | 9. PROVIDER MEDICAID NUMBER |
| PART II COMPLETE A OR B | | |
| If B is completed, the reason the recipient is incapable of signing must be stated on the line provided in Item B. (B is not to be completed if the recipient is capable of signing in Item A.) | | |
| A. TO BE COMPLETED BY THE RECIPIENT RECEIVING THE HYSTERECTOMY PRIOR TO THE OPERATION | | |
| I have received, orally and in writing , information from the above named source, stating that the hysterectomy will render me permanently incapable of reproducing. I understand that I will not be able to become pregnant or bear children. | | |
| 10. SIGNATURE OF RECIPIENT | | 11. DATE (MONTH/DAY/NEAR) |
| B. TO BE COMPLETED BY A REPRESENTATIVE OF THE RECIPIENT RECEIVING THE HYSTERECTOMY | | |
| I, the representative named above, certify that the designated recipient accepts and understands that I am her representative and that she has received, orally and in writing , information from the above named source, stating that the hysterectomy will render her permanently incapable of reproducing. She understands that she will not be able to become pregnant or bear children. | | |
| 12. REASON RECIPIENT INCAPABLE OF SIGNING | | |
| 13. SIGNATURE OF REPRESENTATIVE | 14. RELATIONSHIP TO RECIPIENT | 15. DATE (MONTH/DAY/YEAR) |

MO 886-3280 (11/01/00)

Forms Request

Provider Number: _____
(Or Affix Provider Label Here)

Date: _____

Provider Name: _____

Provider Phone: _____

| CLAIM FORMS | Quantity | |
|---|------------|-------|
| | Preprinted | Blank |
| A. Pharmacy | | |
| B. Dental | | |
| C. HCFA 1500 (Rev 12/90) | | |
| D. HCFA 1450 (UB-92) Inpatient / Outpatient/ Home Health | | |
| | | |
| F. Prior Authorization | | |

CROSSOVER STICKERS

| | |
|---------------------------------------|--|
| G. Hospital Crossover Sticker (BLACK) | |
| H. SNF Crossover Sticker (RED) | |
| I. Part B Crossover Sticker (BLUE) | |

If provider labels are needed with blank Claim Forms (A-F), check box. ☐

If you checked box, an equal number of labels will be supplied with Forms A-F. If you DID NOT check box, you WILL NOT receive labels.

If provider labels are needed and you are not ordering Forms A-F, indicate the quantity _____

SPECIAL MAILING INSTRUCTIONS:

Name: _____

Attn: _____

Street Address: _____

(Not P.O. Box)

City: _____

State: _____ Zip: _____

ADDRESS CHANGE / CORRECTION:

Provider Number: _____

Name: _____

Street Address: _____

(Not P.O. Box)

City: _____

State: _____ Zip: _____

Effective Date of Change: _____

ATTACHMENTS

Quantify

| | |
|--|--|
| J. HCY Medical Screening Tool (All Pages) | |
| HCY Screening Forms by Age Group | |
| 2. Newborn - 1 month/2 - 3 months | |
| 3. 4 - 5 months/6 - 8 months | |
| 4. 9 - 11 months/12 - 14 months | |
| 5. 15 - 17 months/18 - 23 months | |
| 6. 24 months/3 years | |
| 7. 4 years/5 years | |
| 8. 6 - 7 years/8 - 9 years | |
| 9. 10 - 11 years/12 - 13 years | |
| *. 14 - 15 years/16 - 17 years | |
| &. 18 - 19 years/20 years | |
| K. HCY Lead Risk Assessment Guide | |
| L. Sterilization Consent | |
| M. Acknowledge Hysterectomy | |
| | |
| O. Hearing Aid Evaluation | |
| P. Medical Necessity | |
| Q. Adjustment Request | |
| R. Medical Necessity Long Term HPN | |
| S. Second Surgical Opinion | |
| T. Medical Necessity - Abortion | |
| U. Hospice Election Statement | |
| V. Oxygen - Respiratory Justification | |
| W. Notification of Termination of Hospice Benefits | |
| | |
| Y. Insurance Resource Report (TPL-4) | |
| Z. Accident Reporting Form (TPL-2P) | |
| 1. Physician Certification of Terminal Illness | |

* Provider Signature: (Must Be Provider's Original Signature)

All requests are delivered to the address on your current provider label unless an address change or correction is requested above. An address change or correction changes your provider billing label. If Special Mailing Instructions are indicated, this and all future requests for forms from Verizon Data Services are delivered to this address until notice of a change is received. A change to Special Mailing Instructions does not change your provider billing label.

The above forms are provided to all participating-Missouri Medicaid Providers. They are intended solely for Missouri Medicaid claims filing. Please complete the above information and return it to Verizon Data Services via any paper claims submission P.O. Box. For information regarding electronic claims submission, contact Verizon Data Services at (573) 635-3559.

DS1054 (Rev. 11/00)

NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS shall take affirmative action to ensure that employees, applicants for employment, clients, potential clients, and contractors are treated equitably regardless of race, color, national origin, sex, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at 1-800-776-8014. Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

Or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the United States Department of Agriculture at:

USDA Office of Civil Rights
1400 Independence Ave., SW
Mail Stop 9410
Washington, DC 20250

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.



Director, Department of Social Services

04/02/03

Date